Maternal and Child Health Services
Title V Block Grant

State Narrative for Oregon

Application for 2011
Annual Report for 2009

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are on file in the Office of Family Health.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Office of Family Health (OFH) and Oregon Center for Children and Youth with Special Health Needs involves
communities, stakeholders, and program participants, including family consultants, in policy and program decision-making at many levels. The priorities, budgeting and expenditures, performance measures trends and outcomes, are presented and reviewed by stakeholder and program participants of MCH and family health services across Oregon. The Title V and related programs outreach to local public health, tribal health, community-based organizations, primary care, and safety-net providers. The venues range from needs assessment processes and program evaluation to advisory committees and task force efforts.

Oregon Title V Office (Office of Family Health) is developing its website for resources and for public comment on the Block Grant and the Five-Year Needs Assessment priorities. The website and public comment can be found at
http://www.oregon.gov/DHS/ph/ch/mch.shtml. Once the Needs Assessment and priority issues are finalized, the strategy for using this website will be reviewed and updates to assure partners, stakeholders, and the public feel comfortable using this site. The OCCYSHN website (http://www.ohsu.edu/outreach/cdrc/oscshn/index.html) links to this website.

The Five-Year Assessment public engagement activities provided new contacts and strategies for collecting input on plans for implementing the priorities. Regular opportunities for input occur through public meetings and sessions with stakeholders and local partners, such as Conference of Local Health Officials- MCH Committee and local Nursing Supervisors, to discuss policies and capacity in Oregon's state and local Title V programs, including those programs administered by OCCYSHN. Family consultants provide input on program and policy development in both OCCYSHN and in OFH, and link other family consultants to participate in planning activities beyond Title V program areas.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Oregon Five-Year Assessment found some priority needs continuing and others emerging more prominent. The need for better access and more culturally appropriate services continues to be a problem in many communities and among populations, such as access and referral systems to mental health services for all population groups, preventive oral health services, and healthy weight and physical activity. Emerging areas in the 2011 assessment include more critical and difficult issues, such as family violence, and alcohol and drug abuse. For these areas, more research, assessment, and planning to identify those actions and roles for public health to influence a positive health outcome in a generally social justice issue.

In 2006, priorities were more focused on public health and Title V program capacity, with a need for strengthened leadership and surveillance and assessment. The Title V programs have accomplished the capacity goals and the Title V Agency has more internal capacity than five years ago. The cross-cutting priority to improve surveillance of disparities of subpopulations was not accomplished, as the capacity for assessment and surveillance needed to be established first. With a unit and staff firmly in place, this priority will continue and a plan is in place to conduct research and assessment in the context of the new priority areas. For the mental health topic area where, five years ago, the Title V Assessment identified mental health as an issue, but without an identifiable data source to create a performance measure. Activities in the intervening years included policy-changing activities particularly around screening for perinatal depression and for early childhood developmental and social-emotional delays. With these activities just beginning, this year's assessment includes two measures with reliable data sources that can track progress in meeting the needs expressed for these population groups. Overall, the Five-Year Needs Assessment is an opportunity to celebrate accomplishments and gather information to focus on new challenges.

2011-2016 Priority Needs and Goals

1. Need: Family violence prevention, including intimate partner violence and child abuse
   Goal: Improve Oregon's systems and services for screening women for domestic and sexual violence (DSV) and for linking those affected by DSV to adequate services.

2. Need: Alcohol and Drug Use Prevention, including accessibility of services (and prevention of Fetal Alcohol Syndrome
   Goal: Decrease the risk of lifetime dependence on alcohol for teens and adults

3. Need: Mental health including accessibility of services
   Goal: Improve Oregon's systems and services to identify, treat and support women with perinatal mental health disorders and support their infants and families

4. Need: Oral health and early childhood cavities prevention, including accessibility of services
   Goal: Increase the percent of children under 3 years old who have a preventive dental visit each year

5. Need: Parents' resources and parenting behaviors (including parenting education and other support services) to support young children's health, development, safety, and social-emotional health

Goal: Improve the state's capacity for supporting parents in building parent skills and for linking parents to resources.

6. Need: Preventing overweight and obesity
Goal: Prevent and address overweight and obesity in older children and adolescents, including nutrition, food security, physical activity and screen time: Increase the percent of children/adolescents with a healthy body weight

7. Need: Access to preventive physical and mental health services
Goal: Increase access to preventive physical and mental health services

8. Need: Lack of linkages or referral pathways to appropriate mental health services for children and youth with special health needs
Goal: Increase linkages to mental health services for children and youth with special health needs.

9. Need: Limited access to specialized health and related services (specialty care, mental health, PT/OT, etc.) for children and youth with special health needs particularly in rural and frontier areas:
Goal: Increase access to specialized health and related services for underserved populations of children and youth with special health care needs.

10. Need: Families and providers lack knowledge and awareness of support services available for families of children and youth with special health need
Goal: Increase access to family support services among families of children and youth with special health needs.

III. State Overview

A. Overview

Oregon Title V leads and engages partners in the improvement, development and coordination of maternal and child health services system and policies across the state. The Title V Services are administered by two agencies - the Office of Family Health (OFH) in the Department of Human Services, Public Health Division, and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) from within the Child Development and Rehabilitation Center at the Oregon Health and Sciences University. The relationships of the two Title V Offices provide unique partnerships and opportunities for collaborations with state and local public health delivery system and the health professional training and academic research system. Together the Title V Offices assess population health and needs, collaborate and coordinate policy development and implementation, and plan and implement services that reach all of the targeted MCH populations.

The Oregon Agency Title V Overview is organized to give background and context for the delivery of Title V health services, beginning with an overview of the statewide determinants of health, the state's health care delivery system, and a summary of current policy issues. The content is: 1) Geography and Environment; 2) Demographics; 3) Economy and Income; 4) Housing and Education; 5) Safety Net and Health Care System; 6) Oregon Health Authority; 7) Federal Health Reform in Oregon; 8) Oregon Center for Children and Youth with Special Health Needs.

1. Geography and Environment

Oregon is located in the Pacific Northwest with a population of 3.8 million living in 96,981 square miles and is the ninth largest state in the U.S. Oregon's landscape varies from rainforest in the Coast Range to barren desert in the southeast, which still meets the technical definition of a frontier. Oregon shares borders with Washington to the north, California to the south, and Idaho to the east, and a small section of Nevada to the southeast and the Pacific Ocean along its 300 mile western border. Much of these borders are along rural and frontier areas and people transverse these borders for their goods and services.

There are four major mountain ranges that make traveling in Oregon both beautiful and challenging for residents, especially for those living in these areas. Oregon has multiple opportunities for outdoor recreation, from skiing in the winter in these ranges, to camping in one of its 188 state parks, hiking along Coast, in the mountains, or near waterfalls in the Columbia River Gorge, biking along the 40-mile loop in Portland, or kayaking on one of Oregon's many rivers and tributaries. There are 15.7 million acres National Forest Service lands and 15.7 million acres of Bureau of Land Management lands, covering approximately 46.2 percent of the total acreage of Oregon. Agricultural lands cover over 16.3 million acres or over 26 percent of the total land area. Of this, 55.8 percent is pastureland, 3.6 percent is cropland, and 10.5 percent is woodland. (Oregon Dept. of Agriculture, State Facts)

Portland is largest metropolitan area located in the northwestern part of the state, with about 1.8 million people residing in Oregon, and an additional 442,000 living across the Columbia River in Washington, totaling 2.2 million considered the Portland-Vancouver-Hillsboro Metropolitan Statistical Area (MSA), the 23rd largest in the U.S. Other urban centers include Salem, the state capital, Eugene, in the mid-Willamette Valley, and Medford, in Southern Oregon. About 75 percent of Oregonians live in urban areas and 25 percent in rural and frontier areas. Oregon has five Congressional districts.

Oregon is primarily a rural and frontier state, with an overall population density of 37 people per square mile covering 99.1 percent of the state. Population density ranges from about 4,228 persons per square mile in Portland to 7 persons per square mile in frontier areas and 23 persons per square mile in areas with 50,000 or less population (Rural Assistance Center, USDA Economic Research Service). There are 10 federally recognized tribes in Oregon and 43 member tribes participating with the Northwest Portland Area Indian Health Board and other

urban health facilities located in Oregon, Washington and Idaho. The Title V Office of Family Health provides formula grants funded with the MCH Block Grant to three federal tribal government health clinics in Oregon.

2. Demographics

Oregon's estimated population on July 1, 2009 reached 3,823,460. That was an increase of 0.85 percent over the 2008 population. The growth rate has slowed down since the highs of 2005 through 2007 when it exceeded 1.5 percent on average. This is the first time in two decades that Oregon's population growth was lower than the U.S. average. Based on the current forecast, Oregon's population will reach 4.2 million in the year 2017 with an annual rate of growth of 1.17 percent between 2009 and 2017. (Oregon Economic and Revenue Forecast, Vol. XXIX, No. 2, May 2009, Oregon Office of Economic Analysis.)

Oregon's urban areas have more racial and ethnic diversity than the rural and frontier areas of the state. According to the 2008 Census Bureau projections, Oregon's population is about 90.1 percent (3.4 million) White and about 11 percent (416,000) Hispanic (all races). Populations by race and ethnicity include 3.6 percent (137,000) Asian; 2 percent (76,000) African American; 1.4 percent (54,000) American Indian/Alaska Native; 0.3 percent (11,000) Native Hawaiian/Pacific Islander; and 2.5 percent (94,000) that report themselves as two or more races.

Oregon averages 49,000 births per year, and a birth rate of about 13.4 per 1000 live births. Of these births, over 20 percent are Hispanic of all races, while about 69 percent are White, 2.3 percent are African American, less than 2 percent are Native American and 5.3 percent are Asian. Birth rates are lower than the U.S., 66 per 1,000 women aged 15.44 in 2007, compared to the U.S. at 69.2 per 1000. The median age of mothers for all Oregon births was 27 and the median age at first birth was 25. The first birth rate decreased slightly from the previous year to 26.9 first births per 1,000 women age 15-44, slightly lower than the 2007 national rate of 27.9. Age-specific births for women age 15-19 was 35.1 per 1000, 94.4 per 1000 for 20-24 year olds, and 116.1 per 1000 for 25-29 year-olds. The rate per 1000 for women aged 30-24 was 92.9 per 1000. The largest percentage increase was among women aged 35-39 at 48.7 per 1000. (U.S. Census Bureau and Oregon Center for Health Statistics)

Oregon's is one of about nine states with consistent low birthweight percentages below 6.5 percent, while the U.S. was 8.2 percent in 2007, for 2500 grams or less. The U.S. Census Bureau Statistical Abstract for 2006 (latest data available) ranks Oregon 42nd in the country with an infant mortality rate of 5.5 per 1000 live births compared to Oregon the national rate of 6.7 per 1000 live births. Over the past five years, the overall infant mortality rates are about 240-277 per year. About 75 percent of these are White, while small numbers for the remaining populations makes annual calculations unreliable. Generally, the infant mortality rates are higher for Hispanic populations than for infants of other races and ethnicities.

Of the 1,034,458 Oregon children ages birth to 18 years, the 2006 National Survey of Children with Special Health Needs estimates 13.3 percent has one or more special health care needs. Over 100,000, or 22 percent, households in Oregon have one or more children with special health care needs (CSHCN). The proportion of ethnicity of the CSHN population is about the same as the state's population, 11 percent are of Hispanic ethnicity and 16 percent of these children are non-white.

3. Economy and Income

Oregon's economic condition heavily influences the state's population growth and state revenues for public education and services. Migration population change was about 48 percent in 2009, down from 57 percent in 2002. Oregon's employment in trade, transportation and utilities accounts for nearly one in five Oregon jobs. Currently, the top employment industries are food services, administrative and support services, trade contractors and constructions, followed by health care services and hospitals, computer and electronic product manufacturing, and retail services. (Oregon Blue Book, 2009).

Unemployment: Oregon's seasonally adjusted unemployment rate was 10.6 percent in May, 2010 (223,000 Oregonians), peaked in May, 2009 at 11.6 percent. The unemployment rate has essentially unchanged for the past six months and still higher than the U.S. at 9.6 percent. (Oregon Labor Market Information System, http://www.olmis.org/pubs/pressrel/0610.pdf, retrieved, June, 2010).

Income and Poverty: The U.S. Census Bureau ranks Oregon 34th in the country for the three-year average median household income, at $51,394. (U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2006-2008.) The Small Area Income and Poverty Estimates (SAIPE) report for 2008 for Oregon, shows that all populations ages in poverty are 13.5 percent; under age 18 is 17.5 percent and under age 5 is 21.1 percent (http://www.census.gov/cgi-bin/saipe/saipe.cgi). The West Coast Poverty Center reported that, as was the case nationwide, children in the west coast states were generally more likely to live in poverty than working age or elderly adults in 2008. Ethnic and racial minorities in the West Coast states were more likely to be living below poverty than non-Hispanic whites in 2008. http://depts.washington.edu/wcpc/povertyinthewestcoaststates)

According to the 2005/2006 NS-CSHCN, over 40 percent of CSHCN in Oregon are members of households with incomes below the Federal Poverty Level. Over one quarter of CSHCN in Oregon (27.5 %) lived in geographic areas classified as Large Towns or Small Towns/Rural. These areas are located predominantly in the rural or frontier counties in the central and eastern regions of the state.

Over 40 percent of CYHSN ages 0-17 live in household with incomes 100 percent or more of the federal poverty level. Over one quarter of CSHCN in Oregon (27.5 %) lived in geographic areas classified as Large Towns or Small Towns/Rural. These areas are located predominantly in the rural or frontier counties in the central and eastern regions of the state.

State Revenues and Budgets: More than 90 percent of the state's general fund supports three core functions: education; health and human services; and public safety. Oregon is one of five states that does not have a sales tax, which is a benefit for consumers, but the leading source for tax revenue comes from income taxes and therefore highly vulnerable to fluctuations in employment rates. In January, 2010, Oregonians passed two ballot measures that will raise taxes on corporations and on the wealthiest individuals. However, this new revenue will not prevent a $577 million shortfall in the 2009-2011 biennium or a projected $2 billion shortfall in 2011-2013. The Governor has implemented a 9% cut in state agency budgets, which is about $157 in the Department of Human Services agencies. These cuts are in addition to the state employee furloughs for 10 state office closure days and up to 4 additional days, over the 24 month budget period.

Federal funds continue to assist during times of state revenue shortfalls. The state public health system in Oregon is supported by primarily federal funds with 74% compared with 8% state general funds. (Association of State and Territorial Officials, 2009). Oregon is ranked 42nd in the country in state general fund investment in public health services, dropping from 36th in the country in 2008, according to the American Public Health Association, Partnership for Prevention and United Health Foundation.)

The American Recovery and Reinvestment Act (ARRA) adopted in 2009, provides federal funding to states, including Oregon, to assist in the country's economic recovery. Oregon is receiving an additional $900 million to help fund Medicaid programs in the current biennium through December 31, 2010. Under ARRA, the federal share is 73 percent and state is 27 percent or $2.70 for every Oregon dollar. This will end in December 2010 and Oregon will revert to the previous funding levels, which is a 67 percent federal share or $1.70 for every Oregon dollar.

4. Housing and Education

Housing: The American Community Survey (U.S. Census Bureau), estimates that Oregon had a total of 1.6 million housing units, 9 percent of which were vacant during 2006-2008. Oregon ranks 12th in the country in foreclosure rates as of March, 2010. Oregon households that spent 30 percent or more of their income on housing, 49 percent were renters, 40 percent were owners with mortgages, and 15 percent were owners without mortgages. The median monthly housing costs for mortgaged owners was $1,551, non-mortgaged owners $413, and renters $770. Four percent of the households did not have telephone service and 8 percent of the households did not have access to a car, truck, or van for private use. (U.S. Census Bureau. Oregon Population and Housing Narrative Profile: 2006-2008, American Community Survey 3-Year Estimates.)

According to 2008 U.S. Housing and Urban Development (HUD) data, 97 percent of the almost 6,000 contracted subsidized housing units were occupied in Oregon, housing about 10,000 people. Of the households with children 18 years and younger, 15 percent had two adult households and 24 percent are one adult households, and 34 percent have females as the head of households.

Education: Oregon's education system starts at birth when infants are screened for early developmental delays and medical problems and referred to services for early development interventions or medical interventions. Over the lifespan, children have access to private and public preschools and pre-kindergarten, Head Start, public schools, community colleges, universities and graduate studies.

According to the 2009 IDEA Part C Annual Performance Report, 2,762 total children aged birth to 3 years of age received services 33 EI/ECSE programs in Oregon in 9 service areas with an Individualized Family Service Plan (IFSP). Each site serves from 112 to 444 children with IFSPs. Of those ages birth to three with an IFSP, 21.7 percent were Hispanic and 70.1 percent were White, and 2.9 percent were African American. Almost 64 percent were male and 87.3 percent were receiving services for developmental disabilities. The number of 3-4 year olds enrolled in pre-kindergarten special education was 5,703 or 6.1 percent of the population. The proportion of children engaged with EI/ESCE represents about the 3.5 percent of the total child population aged birth to 4.

Oregon has six Early Head Start sites in Oregon, funded directly from the federal Office of Head Start and 37 Head Start grantees, funded by the federal Office of Head Start and the Oregon Department of Education. As of January, 2009, there were 1,018 children, or 3 percent of the eligible population, under age 3, were enrolled in Early Head Start, and 12,582 children were enrolled in Head Start or 68% of eligible families, including Native American children served by Tribal governments and children of seasonal farm worker families. The Migrant/ Seasonal Head Start (Oregon Child Development Coalition) serves an additional 1,877 children, ages 0-5, from mobile migrant farm worker families.

Oregon has 198 public school districts, which operate a total of 1,306 public schools, enrolling a total of 561,698 students from kindergarten through grade 12 for 2009-2010 school year. While Oregon schools have a much lower proportion of minority enrollment compared to the U.S. average, other measures show that Oregon students are more likely than the national average to be non-English speaking or participating in the free and reduced-price school lunch program (Oregon Blue Book, 2010). In 2008-09, Oregon Department of Education data reports that 41,198 persons completed high school, of which 35.6 percent are considered economically disadvantaged, and Oregon has a drop-rate of 3.4 percent. (Oregon Department of Education).

Oregon has 17 community colleges, enrolling over 91,000 students in the 2007-08 school year, 7 public universities, enrolling over 112,000 students, and another 37,000 are enrolled in Oregon 20 non-profit accredited universities. Oregon has one academic research school, the Oregon Health and Science University (OHSU) which includes schools of medicine, dentistry, nursing and science and engineering, as well as the Child Development and Research Center and

OCCYSHN. Title V offices and local providers have a strong tradition of partnerships with these education institutions to help train and employ graduates from Oregon schools.

5. Safety Net and Health Care System

Oregon's public health statutes and programs are administered by the Public Health Division (Oregon Health Authority) and each of 36 county jurisdictions are the designated health authority. Currently, there are 33 county health departments and 1 health district serving 3 small rural county populations. Primary care and safety net health services are available through private medical providers and through the following facilities.

Total Health Care Facilities: 263 Clinics and 58 Hospitals in 116 Sites
Federally Qualified Health Centers: 93 Clinics in 46 Cities and 25 Counties
Rural Health Clinics: 57 Clinics in 43 Cities and 24 Counties
Migrant Health Centers: 15 centers in 12 cities in 10 counties
Tribal and Indian Health Service: 11 Clinics among 9 Tribes and 9 Counties
School Based Health Centers: 54 Clinics in 20 Counties
Oregon Community Sponsored/Other Clinics: 33 Clinics in 12 Cities and 10 Counties

Oregon's Health Professional Shortage Areas (HPSA), established by the Office of Shortage Designation, Bureau of Health Professionals, to determine where reports 102 designations for primary care in Oregon in 15 service areas, and 54 practitioners needed to remove designation. There are 76 HPSA dental care designations and 118 dental practitioners are needed and 54 mental health HPSA designations and 20 practitioners needed to remove the designation. Mean travel to time to nearest hospital across Oregon is 23.7 minutes in the unmet need areas of rural Oregon, with several areas up to an hour or more to the nearest hospital facility. Thirty-seven rural towns had a 10 minute travel time to the nearest hospital. (Oregon Office of Rural Health). At least one practicing pediatrician is practicing in 23 of Oregon's 36, and of the 13 counties without a practicing pediatrician, 11 are located in rural or frontier counties Children living near eastern and northeastern Oregon border are more likely to travel to Boise, Idaho, or to Washington State than to Portland or other metropolitan areas in Oregon. However, a lack of Medicaid interstate transportability has made it increasingly difficult for children to receive care in Idaho or Washington.

Health Safety Net Access: Oregon's safety net health care system provides vulnerable and underserved individuals with prenatal care, immunizations, treatment for communicable diseases and chronic disease management. The Safety Net System cares for over 270,000 patients, including about 720,000 primary care visits, nearly 150,000 mental/behavioral health visits, nearly 110,000 oral health visits. Patients seen by federally supported clinics include about 60,000 well-child health supervision patients, aged birth to 11 years, 12,500 migrant/seasonal farm-worker patients, and 19,212 homeless patients. The Oregon Primary Care Association reports that 24,686 homeless used Federal Qualified Health Centers (FQHC) in 2008. Also, migrant and seasonal farm workers usage of FQHC's increased from 16,491 in 2001 to 19,595 in 2007 and a high of 22,226 in 2008. (Oregon Primary Care Association, 2008).

Oregon's safety net includes certified School Based Health Centers are located in 31 high schools, 4 middle schools, 11 elementary schools, and 8 combined-grade campuses. Eleven counties are using planning grants to create 14 new certified centers. In 2009, there were 47,511 students with access to SBHCs at their schools and SBHCs served nearly 25,000 students with over 72,000 visits, and 47 percent of these clients were uninsured.

Geography represents a significant barrier to obtaining care, particularly specialty care, for CSHCN. Specialty care services for children are concentrated in the urban areas, particularly Portland, where the only teaching hospital, Oregon Health & Science University (OHSU), is located. Cardiology is the most common specialty service available in these and other outlying communities. Little or no specialty care services are available in the rural and frontier counties of central or eastern Oregon. Similar to the rest of the nation, dental and mental health services are

the most difficult services to access geographically, and is particularly for CYSHN and their families, as providers in their areas are not trained to provide care to CYSHN. Families of CYSHN are burdened financially and with time away from work, not to mention the difficulty of traveling in winter, to receive specialty services for their children in Oregon's urban areas.

Birth deliveries: In Oregon, most infants are born in hospitals (80.9 percent) and delivered by physicians. However, there has been an increase in prevalence of births attended by certified nurse midwives (CNM) in hospitals and out of hospitals. In 2007, 15.4 percent of hospital deliveries were CNM-attended, a slight increase from 2006 (14.6 percent) and almost three times the proportion in 1988 (5.3 percent). This is almost twice the national proportion of 7.4 percent births attended by CNM. The proportion of out-of-hospital births was almost double that of the U.S. births, with about 2.5 percent of Oregon births occurred out-of-hospital in 2007 compared to 2006 U.S. proportion, most recent data available, of 0.9 percent. As in past years, the majority of out-of-hospital births occurred in the mother's home (67.8 percent). More than one-fourth of the births occurring out-of hospital and 345 births were at freestanding birthing centers. Out-of-hospital births were predominately attended by licensed direct entry midwives (LDM), who delivered over half of the out-of-hospital births in 2007. Both certified nurse midwives and naturopathic physicians delivered approximately one in 10 out-of-hospital births and non-medical attendants, including non-licensed lay midwives, delivered 346 babies or 27.3 percent of the out-of-hospital births. The majority of births (69.8 per 100) continue to be vaginal deliveries without prior cesarean, while the rate of delivery in 2007 was 28.9 per 100 births, well below the 2007 national rate of 31.8 per 100 births. The rate for vaginal delivery after a previous cesarean was only 1.3 while repeat cesarean was 12.2 per 100 births. (Oregon Center for Health Statistics, 2006 and 2007 Annual Reports).

Health Insurance: The 2008 American Community Survey reports that Oregon is 35th in the country for individuals without health insurance with 16.5 percent uninsured. This survey also reports that private insurance covers the 2.6 million residents in Oregon. These data were collected a year before Oregon's unemployment rate 12.6 percent in early 2009, so it is assumed the rate of uninsurance has increased dramatically. The uninsured Hispanic/Latino population was 35.1 percent, or 144,000 Hispanics without health insurance. (Oregon Health Policy and Research: Oregon's Uninsured: Analysis of the 2008 American Community Survey, May 2010).

Oregon Health Plan (OHP) Overview: Between 1989 and 1993, the Oregon Legislature passed a series of laws that have become known as the Oregon Health Plan. The Legislation expanded Medicaid coverage to Oregonians with incomes below the federal poverty level, who would not ordinarily be eligible and established a set of benefits based on a prioritized list of health services. The OHP is a public/private partnership made up of three main components: Medicaid reform and expansion, private and employer-sponsored insurance subsidy to help those not eligible for Oregon Medicaid (Office of Private Health Partnerships), and the Prioritized List of Health Services, managed by the Health Services Commission (HSC). The Prioritized List of Health Services is a ranking to the entire population to be covered, based on relative importance and the effectiveness of a clinical intervention as gauged by public input and the clinical expertise on the HSC judgment. Within categories of health services (e.g., maternity and newborn care; comfort care), individual condition/treatment pairs (e.g., ICD-9 and CPT codes) are prioritized according to impact on health and demonstrated effectiveness. The resulting prioritized list is used by the Legislature to allocate funding for Medicaid and SCHIP, but the Legislature cannot change the priorities set by the independent Commission. Prevention tables guide standards for preventive services by age groupings and correspond to the prioritized list. It is important to note that perinatal care, child and adolescent preventive services are at the top of the list.

The Division of Medical Assistance Programs (DMAP) administers the Oregon Health Plan. Currently, most adults, aged 19-64 with incomes up to 100% FPL are eligible for OHP Standard, for which there is a waiting list. Pregnant women and persons with disabilities with incomes up to 185% FPL are eligible for OHP Plus. Oregon does not have a presumptive eligibility law for pregnant women. OHP Plus includes Oregon's SCHIP program, now called "Healthy Kids,"

which covers children up to age 19, who have or are in families with incomes up to 200% FPL, with subsidies for co-pays and/or premiums for employer plans.

As of April 2010, DMAP reports that 522,704 people were enrolled in the Oregon Health Plan Standard and Plus. Of those, over 60 percent are White, over 23 percent are Hispanic or Latino, about 4 percent were Black/African American, almost 2% were American Indian/Alaskan Native, and almost 7 percent reported other or unknown race or ethnicity. (DMAP, DSSURS data warehouse, 5/3/2010).

To increase access to early prenatal care, DMAP implemented a pilot program in two counties to provide prenatal care to women who do not have access to these services under a traditional Medicaid program. State/county partnerships were established to put together the required financial match to acquire federal SCHIP funds for the project: 73 percent federal funds, 25 percent state funds, and 2 percent county funds. The pilot was for pregnant women residing in Multnomah (urban) or Deschutes (rural) Counties who are not eligible for any Medical Assistance coverage other than CAWEM (Citizen-Alien Waived Emergent Medical), such as undocumented immigrants, or immigrants with documentation who have not completed their five year US residency requirement. When the pregnancy ends, the mother returns to regular CAWEM status and the newborn child will be covered for up to a year before eligibility will be re-determined. The CAWEM prenatal care project is expanding to up to 7-10 more counties in 2010.

Healthy Kids (HK) is an OHP program approved by the 2009 Legislature (HB 3418) as a significant part of the overall health reform passed in Oregon that year. Healthy Kids aims to insure all children up to age 19, reducing the uninsurance rate from 12 percent to 5 percent by 2011. The federal SCHIP program is integrated into Healthy Kids/OHP. As of May, 2010, over 318,000 children age 19 or less, were enrolled in Healthy Kids/Oregon Health Plan, a 17.76% increase over June 2009. The law imposes a tax on hospitals and health plans to fund the insurance expansion, school based health centers expansion, and, increases reimbursement rates. There are three avenues of coverage: 1) Oregon Health Plan (OHP) Plus (Medicaid); 2) Employer Sponsored Insurance (ESI) insurance; or 3) Healthy KidsConnect, a private market insurance option. Children in families earning 200% FPL ($44,100 for a family of four) or less will receive Healthy Kids coverage at no cost. Children in families between 200% and 300% FPL will receive a sliding scale subsidy for the cost of their premium.

The Healthy KidsConnect (HKC) plan is for families with eligible uninsured children between 201% through 300% FPL can receive a premium subsidy for insurance carriers contracted n the HKC program. Uninsured children above 300% FPL can purchase coverage through the HKC program by paying the full premium cost. For the Employer Sponsored Insurance (ESI) component, those families who are at 300 % FPL or higher can receive premium assistance in the form of a reimbursement, as long as the employer plan meets federal guidelines. As of March, 2010, there were 832 enrolled in HKC/Oregon Health Plan; 74% had incomes between 201% and 250% FPL, 25% had incomes between 251% - 300% FPL, and 1% or 9 children of families over 300% FPL, were helped with HKC.

6. Oregon Health Authority

The Oregon Health Authority (OHA) is a new state agency created by HB 2009 by the 2009 Legislature. By July 2011, most health-related programs in the state will be joined together to form the Health Authority. The Oregon Health Policy Board oversees the OHA and is a nine-member, citizen-led board appointed by the Governor and confirmed by the Senate.

The Oregon Health Authority will streamline state health functions including state health agencies and purchasers into one agency to improve efficiencies in the state's patchwork of health policy and health issues. OHA is mandated to implement a public employer purchasing collaborative, clinical improvement assessment project, patient-centered primary care homes and payment reform, coordination of electronic health record adoption and interconnectivity, health care workforce initiative, and improve transparency for healthcare facilities, insurers, and claims

reporting. The OHA has adopted a "triple aim" set of goals to transform the health care system in Oregon by:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone

Three DHS divisions will move to OHA: Addictions and Mental Health Division (AMHD), Division of Medical Assistance Programs (Oregon Health Plan/Medicaid), Office for Oregon Health Policy and Research (OHPR), and the Public Health Division. Child welfare, seniors and people with disabilities, and the food stamp program will remain in DHS. Unique to the OHA are the other programs joining the former DHS agencies including: Family Health Insurance Assistance Program (FHIAP), Oregon Educators Benefit Board (OEBB), Oregon Medical Insurance Pool (OMIP), Oregon Private Health Partnerships (OPHP), Oregon Prescription Drug program (OPDP), and the Public Employee Benefit Board (PEBB). The joining of public and private health care services offers unique opportunities to bridge the gap between population-based preventive care and individual and family health care coverage and coordinated services.

Health (Medical) Homes: With the passage of House Bills 2009 and 2116 in 2009, the Oregon Legislature created the Patient Centered Primary Care Home advisory committee under the Office of Health Policy and Research. The Advisory Committee was charged with guiding Oregon Health Policy and Research in the development of standards and quality measures. Oregon's Medicaid agency was mandated to develop a payment system to fund the "integrated health home" model for providers. The intent is to find ways to fund the services that link and coordinate primary care, mental health care, and the care coordination that must occur between those services. A study and report is due to the 2011 Legislative session with recommendations for implementing "Health Home" model in Oregon's public health services.

CHIPRA Quality Improvement Demonstration Grant: An $11 million grant was awarded to the Tri-state Children's Health Improvement Consortium (T-CHIC), an alliance between the Alaska, Oregon, and West Virginia Medicaid/CHIP programs formed to improve children's health care quality. The Oregon-led consortium, working in collaboration with the state Medicaid/CHIP programs, expert consultants, and a broad range of stakeholders, will demonstrate the unique and combined impact of patient-centered care models and health information technology (HIT) on the quality of children's healthcare. The project will assess child health quality measures and the identification of the features of patient-centered care models -- including their incorporation of HIT and electronic information exchange -- that produce the greatest improvements in quality across a range of provider types, delivery systems, and geographic settings. The T-CHIC's proposal rests on three major strategies: development and validation of quality measures, including the AHRQ/CMS initial core measures; infrastructure improvement for electronic or personal health records (EHRs/PHRs) within robust health information exchanges; and implementation and evaluation of patient-centered care models such as medical homes and care coordination hubs.

Improvement Partnership: In 2009, Oregon was awarded a technical assistance grant to create a child health improvement partnership (IP), from the Vermont Child Health Improvement Partnership. The Oregon IP is a public-private partnership of the Dept. of Pediatrics in Oregon Health and Science University, Child and Adolescent Health Measurement Initiative (CAHMI) also in OHSU, Oregon Health Authority -- Office of Family Health (Title V) and Division of Medical Assistance Programs (DMAP-Medicaid), the Oregon Center for Children and Youth with Special Health Needs (OCCSYHN -- Title V), the Children's Health Foundation, the Oregon Pediatric Society, and the Oregon Rural Practice Based Research Network (at OHSU). The IP is being launched in Summer, 2010, and will work to create a quality improvement initiative for child health providers through development and standardization of practices and measurement at the clinical level.

7. Federal Health Reform in Oregon

Electronic Health Records: Oregon will jumpstart another key element of health care reform -- increasing the use and effectiveness of electronic health record technologies -- through two federal grant awards. Through the American Recovery and Reinvestment Act (ARRA) of 2009, Oregon will receive more than $21 million over the next four years to develop a system of statewide health information exchange between hospitals, doctors' offices, pharmacies and other health care providers and help health systems develop electronic health record systems. The $21 million will be allocated through two grants. The Office for Oregon Health Policy and Research will receive $8.58 million to administer for the Health Information Technology Oversight Council to develop plans for secure statewide health information exchange (HIE) between providers and across jurisdictions. The second grant, for $13.2 million, went to OCHIN Inc. and Oregon Health & Sciences University, as partners in Oregon's designated Regional Extension Center (REC). The organizations will provide technical assistance to health care providers to purchase, upgrade and implement health care providers' electronic health record systems. Oregon's center is one of dozens set up across the country for this purpose. The centers, modeled on the national agricultural extension center system, will also be central places to share information and best practices. OHA agencies including Title V and SSDI (State Systems Development Initiative) are participating on work groups for these projects.

The development of electronic infrastructure for secure transmittal of relevant patient information will help lower Oregon's health care costs and ensure the most effective and efficient care in every setting. Oregon providers use electronic records at a higher rate than most states. Approximately 66 percent of Oregon clinicians (physicians, nurse practitioners and physician assistants) work in practices or clinics with access to electronic health records, compared to 44 percent nationally. The Oregon health reform legislation, HB 2009, established a Health Information Technology Oversight (HITO) Council within the Oregon Health Authority. The HITO Council will coordinate Oregon's public and private statewide efforts in adopting electronic health records and develop a statewide system for health information exchange. The information exchange will give providers a secure and instant access to medical history, prescriptions, allergies, and help consumers avoid unnecessary and invasive tests. Insurance claims and billing information will also be handled electronically, saving time and money across the health care system.

State Health Access Program (SHAP): The Health Resources and Services Administration (HRSA) awarded $70.9 million in grants to 13 states under the State Health Access Program (SHAP). Oregon was awarded $9.96 million for the first year of the program, the second highest award among all 13 states receiving this grant, with an additional planned request for total of $43.8 million over the five year period. The HRSA SHAP grant goal is to support state efforts to significantly increase health care coverage as part of a plan for comprehensive health reform. The SHAP grant funds will augment and strengthen efforts to expand coverage legislated under HB 2009, and will assist implementation planning for broader coverage expansions. Aligning with Oregon's legislative priorities, initial emphasis will be on implementing coverage programs for all uninsured children and for adults under 100 percent of FPL and then taking steps to provide affordable, sustainable coverage options for all Oregonians, including: health insurance exchange; affordable small business insurance product; reinsurance strategies to reduce insurance costs; and, "multi-share" models that would utilize contributions from employers, employees, and the community to finance health care for working uninsured.

Children's Health Insurance Program Reauthorization Act (CHIPRA): The Children's Health Equity Outreach Project (CHEOP) is a federally funded outreach and enrollment grant through the CHIPRA, administered through the Centers for Medicare and Medicaid Services. The grant is administered by the Office of Family Health, in collaboration and coordination with the Office of Healthy Kids. The grant uses a public health approach in communities to reach and enroll a significant portion of the eligible uninsured children in the state, those citizen and legal resident children living in mixed status and unauthorized immigrant households. CHEOP reaches eligible children through the Safety Net Providers' existing community networks and local expertise. The goal for CHEOP is to outreach to at least 12,000 children and enroll 6,000 children in the

intended population. Grantees will develop and/or support sustainable community level systems and partnerships that support outreach and enrollment efforts.

Patient Protection and Affordable Care Act (PPACA) in Oregon:
Federal Health Reform legislation of 2010 complements and affirms Oregon's House Bill 2009 and the creation of the Oregon Health Authority. Like HB 2009 which created the Oregon Health Authority, the federal legislation creates an exchange that allows people and small businesses without group care to shop and compare prices and policies. An affordable option will be available for adults, similar to the Healthy Kids Plan. Additionally, the federal legislation helps to expand Oregon Health Plan coverage to low-income working families and make it more feasible to achieve Oregon's goal of affordable health care for all by 2015. The legislation will bring $5 billion in new Medicaid funds to Oregon over the next 10 years. Oregon's high-risk health insurance pool provides coverage for people who have been blocked from other health care plans is already up and running. This pool will provide a bridge to 2014 when the federal legislation prohibits private insurance carriers from denying coverage to people with pre-existing conditions. Oregon has begun working on establishing electronic health record systems and quality standards for health care providers and hospitals. The Oregon Health Authority is well-positioned to be a national leader in these elements contained in the federal legislation. Under Oregon HB 2009, the OHA and the Board will deliver a comprehensive blueprint that will ensure coverage for all Oregonians by 2015. [Oregon Health Authority http://www.oregon.gov/OHA/features/feature_federal_intersect_ore.shtml, retrieved 6/10/2010]

PPACA: Home Visiting Restructure: Oregon Title V Programs in the Office of Family Health and in the Oregon Center for Children and Youth with Special Health Needs are collaborating with state and local partners and stakeholders to redesign the service structure for home visiting in Oregon. OFH staff is leading a cross-agency work group to conduct the required needs assessment for home visiting, and will lead the development and submission of the application, assessment and plan for Oregon. The structure will provide home visiting, maternity case management and assessment of risks for pregnant women through public health (and Title V) services. The family will then be triaged to either a evidence-based home visiting services targeted to either high risk or lower risk families.

PPACA: Personal Responsibility Grants: Oregon submitted an application for the federal CDC grant funds for the Teen Pregnancy Prevention Cooperative Agreement. to replicate with fidelity the Safer Sex intervention (Shrier LA, et al. Randomized controlled trial of a safer sex intervention for high-risk adolescent girls. Arch Pediatrics and Adolescent Medicine 2001; 155: 73-79). The overall goal of Oregon Safer Sex Project is to improve sexual health of adolescent females by improving risk knowledge and reducing risk behaviors. The intervention is expected to increase condom use and decrease number of sexual partners among participants. The state Adolescent Health Section will coordinate the Oregon Safer Sex Project with other teen pregnancy prevention initiatives through the existing statewide Teen Pregnancy Prevention-Sexual Health Partnership with the Children, Adults and Family Division and TANF programs.

8. Oregon Center for Children and Youth with Special Health Needs
It is estimated that 14 to 18 percent of Oregon children birth to 21 years have special health needs. Significant advances in science and technology have reduced the risk of mortality for CSHCN, resulting in an increase in morbidity due to chronic illnesses. More youth and young adults with special health needs are living longer and assuming productive lives. However, fewer than 30 percent of these youth and young adults are employed, due to lack of experience in managing their own health and unaware of available resources to support their health needs.

According to the 2005/2006 National Survey of CSHCN, 116,988 Oregon children have a special health need, and 5,138 of these children have a condition that significantly interferes with day-to-day activities. Children with cerebral palsy, autism, arthritis, Down syndrome, ADHD, rare metabolic disorders, spina bifida, cleft lip and palate, and mental and behavioral disorders

represent the diversity of the population served by the Title V CSHCN program. Oregon has one of the highest reported prevalence rates of Autism Spectrum Disorder (ASD) in the country (7.6% v 5% nationally). Nearly 8,000 Oregon children and youth ages 3 to 21 years are currently identified with ASD according to the Oregon Department of Education within Oregon's educational system.

Every child in Oregon identified as in need of special education has at least one of the disabilities defined in the Individuals with Disabilities Education Act (IDEA). In Oregon, children must have an established diagnosis of developmental delay in order to receive EI services; children who are at risk of developmental delay are not served by Early Intervention or Special Education. The total number of Oregon children, age 0-21, in special education was 80,062 and 2,762 children received early intervention (EI) services (Oregon Department of Education, IDEA Part C, 2008-2009). The majority of the 9,360 children under the age of 18 receiving federally administered SSI payments lived in their parent's household and according to the Office for Seniors and Developmental Disabilities Services.

Birth Anomalies: Oregon does not currently have a birth anomalies registry. Children with risk factors or conditions that receive services through the Care Coordination program (CaCoon) are tracked through a statewide database. The most frequent risk factors and conditions cited for CaCoon recipients during FY '09 were developmental delay, congenital heart disease, genetic disorders, oral motor dysfunction and other chronic conditions. Children can have more than one risk factor recorded. During FY 09, approximately 69 percent of children in the CaCoon program had multiple risk factors. Several additional risk factors were added to the database last year including fetal alcohol syndrome, Autism spectrum disorder, and behavioral or mental health disorders that are coexisting with developmental delays. Over past several years, Oregon initiated a surveillance system for fetal alcohol spectrum disorders (FASD) in the Office of Family Health. Data from this system are currently being compiled and analyzed.

Autism: The Oregon Commission on Autism Spectrum Disorder (OCASD) was created by Executive Order of the Governor in 2009. The commission is charged with developing and monitoring the implementation of a ten-year strategic plan to address services for individuals with autism, engaging stakeholders, setting priorities, and proposing legislation. Recommendations for improvement have been finalized by the Oregon Commission on Autism Spectrum Disorders (OCASD) and include increased expertise of healthcare providers, a collaborative approach of families and professionals, identification and access to resources and service coordination. OCCYSHN has applied for a HRSA grant to implement the Oregon Collaboration for Autism: Redesigning and Enhancing Healthcare Systems (CARES). The CARES project will improve transition to the adult healthcare system and family supports of youth with Autism Spectrum Disorders (ASDs) and other developmental disabilities. Adult HCPs will receive training and mentoring by local champion HCPs in screening, referral and management of youth with ASDs; families will be educated about family support and involved in training adult HCPs in care practices. The project will develop and offer training, tools and support to enhance the adult healthcare system for youth with ASD and their families. OCCYSHN's professional partnerships and community-based programs will serve as the basic framework for project activities. A Family Professional Partnership model will be maintained throughout this project including family involvement in the training content and development. Community Champions will be trained and mentored in current, effective models of care and practice to promote early initiation of transition planning.

CYSHN Medical Home: OCCYSHN is renewing its commitment to ensure that children and youth with special health needs will receive coordinated, ongoing, comprehensive care within a medical home. The goals will ensure that the needs of the CYSHN population are integrated into OHA Health Home policies and will increase medical home practices that meet the needs of this population. The initiative objectives will incorporate the needs of CYSHN into the definition and recognition of medical homes, into improved purchasing and reimbursement policies, and in practice change. The initiative is focused on the transition from pediatric to adult health care for

three specific groups of the CYSHN population: individuals with intellectual disabilities including autism spectrum disorders; individuals with complex mental health conditions; individuals with rare chronic health conditions. The Initiative is engaging partners and stakeholders from state agencies, professional groups, and local stakeholders. The Initiative is expected to improve care to CYSHN by systematized medical home practices in clinics, increased access for CYSHN, increased satisfaction for individuals and families, and increased satisfaction for providers.

B. Agency Capacity

Overview of Title V Program Capacity Goals

The mission of the Office of Family Health is to provide leadership for improving health outcomes for women, children, and families through:

- Collecting and sharing data to assess the health of women, children, and families;
- Developing and implementing public health policy based on these data;
- Assuring the availability, quality and accessibility of health services and health promotion; and,
- Providing technical assistance, consultation, and resources to local health departments, and other community partners.

The mission of OCCYSHN is to improve the health, development, and well-being of children and youth with special health needs, through the following activities:

- Partner with families, communities, providers and agencies
- Provide leadership in policy development, advocacy and assessing levels of care and services;
- Support efforts to coordinate and maximize resources;
- Work with communities to strengthen their capacity to meet the needs of children and their families;
- Honor the strengths and diversity of families.

State Statutes related to Title V

The Title V Agency for Oregon is the Office of Family Health (OFH) in the Oregon Health Authority, located in Portland, Oregon. ORS 431.375 authorizes Oregon Health Authority (OHA) …"To provide for basic public health services the state, in partnership with county governments, shall maintain and improve public health services through county or district administered public health programs." ORS 431.375(4) authorizes the Oregon Health Authority "…contract for the provision of maternal and child public health services with any tribal governing council of a federally recognized Indian tribe that requests to receive funding and to deliver services under the federal Title V Maternal and Child Health Services Block Grant Program."

The Oregon Revised Statutes (ORS) 444.010, 444.020 and 444.030 , the Oregon Health and Science University (OHSU) is designated to administer a program to extend and improve services for children with special health needs, including the administration of federal funds made available to Oregon for services for children with disabilities and children with special health needs. Within OHSU, the Child Development and Rehabilitation Center administers and implements the Title V Block Grant program for children with special health care needs.

The Title V Program in the OHA and the Title V Program for CYSHN in OHSU have an interagency agreement to document the roles of each agency and to directly transfer 30% of the Title V allocation (without indirect costs). State Title V Agencies in OFH and OCCYSHN collaborate in coordinating service delivery, building partnerships, identifying gaps and opportunities in delivery systems, and advocating for actions and policies that improve health among maternal and child populations. The state Title V programs support community MCH programs through intergovernmental agreements and formula grants with county health departments and tribal governments. There are no satellite state MCH offices in counties, though OCCSYHN works through the CDRC site in Eugene in the middle of the state.

County governments are the designated health authorities delivering health and mental health services and/or linking the public to health and mental health services, through county or regional health departments. Local Title V programs are defined as county health departments and tribal governments who are receiving Block Grant funds through contracts with the state Title V program. There are currently 34 county health departments, 1 regional health department (three rural counties), and 3 tribal governments receiving Block Grant funds. Local partner agencies include the DHS regional offices for social services such as self-sufficiency, food stamps, disabilities, and foster care; regional offices for the Education Service Districts for early intervention and special education services (Part B and Part C services), to services and providers for children and youth with special health needs, and to private or public primary care, mental health, and dental health providers, including insurance enrollment.

Preventive and Primary Care Services for MCH Populations
Capacity and services for Oregon's MCH populations are described organizationally around programs in the Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs.

Capacity and Services For Women Before and Between Pregnancy
The Reproductive and Women's Health Section assures preconception and reproductive health services are available across the state through several federal and state programs. The Family Planning Program includes the Family Planning Expansion Project (FPEP), under a HCFA 1115 waiver and the federal Title X Family Planning programs. Oregon's Family Planning Programs contracts, funds and provides technical assistance with local Family Planning clinics who deliver health services, health education and counseling about reproductive and preventive health concerns, such as breast/testicular self-examination, birth control, STD/HIV risks, infertility, pregnancy counseling, and domestic violence.. Title V supports services for individuals not eligible for FPEP.

The Women's Health Program is a systems development program to raise awareness, engage stakeholders, and improve resources for women's health concerns across the lifespan. This Program oversees preconception health and domestic violence prevention assistance. Preconception Health is a policy focus area in OFH that aims to assure that preconception health is the norm for Oregon women of reproductive age through promotion of preconception health with women planning a pregnancy within the 2 months. The Oregon Public Health Preconception Health Action Plan was created by a collaboration of Oregon's state and local Maternal and Child Health public health agencies created in 2008. This plan provides guidance for continuing development of preconception strategies across MCH programs. The Sexual Violence Prevention Program is the Rape Prevention and Education (RPE) funding from the Centers for Disease Control and Prevention (CDC), and participates on a statewide sexual violence prevention planning committee to implement "Recommendations to Prevent Sexual Violence in Oregon: A Plan of Action" (2006).

The Breast and Cervical Cancer Program (BCCP) helps women access screening programs for early detection of breast and cervical cancers. BCCP is funded by the Centers for Disease Control and Prevention and the Susan G. Komen for the Cure Oregon. Each year, approximately 7,000 eligible individuals receive screening services. The WISEWOMAN Program is a CDC program "Well-integrated Screening and Evaluation for Women Across the Nation" -- WISEWOMAN -- promotes early detection, risk factor screening, risk reduction and access to medical treatment for low-income, uninsured and underinsured women aged 40 to 64, with incomes up to 250% FPL and who are receiving screening services through the Oregon BCC. BCCP contracts with a network of qualified providers, who have an approved medical services agreement to provide screening and services through this program. The majority of the funds are used to reimburse health care providers on a fee for service basis for office visits and colorectal cancer screenings for low-income, uninsured Oregonians.

Capacity and Services For Pregnant Women, Mothers and Infants, and Young Children

The Maternal and Child Health Section in the Office of Family Health administers a majority of the MCH services and programs for pregnant women and children. The section also includes an assessment and evaluation unit devoted to surveillance, evaluation and ensuring program impact; a policy unit that explores and addresses emerging issues and practices; and a communications unit that ensures effective outreach with communities and partners.

Perinatal Health Program aims to improve the health of pregnant women and birth outcomes through promotion of optimal prenatal care and other pregnancy related services for all pregnant women. Title V resources support statewide policy development, surveillance, and local funding for improving the health of periconceptual and pregnant women. Program activities include technical assistance and consultation with local health departments in delivery of perinatal services including outreach, advocacy, systems development, community-based health education; and administering the Pregnancy Risk Assessment Monitoring System (PRAMS). Maternity Case Management (MCM) services are provided by county health departments, contracted health plans and private providers through the Oregon Health Plan (OHP). MCM services include assessment of the pregnant woman's individual strengths and needs; development, implementation and monitoring of a client service plan and communication with the client's prenatal care provider; client education; assessment of the client's home and environment for health and safety; and ongoing referral and linkage to necessary services. The Oregon MothersCare (OMC) Program supports early access to prenatal care for all Oregon women. OMC links pregnant women to health insurance benefits and community resources, including oral health care. OMC sites area partner with state and local government, non-profit agencies, and private medical and dental providers. There are currently 28 OMC sites in Oregon in 23 counties, providing services to over 5,000 pregnant women per year. Another program incorporated into perinatal home visiting program is the screening for environmental health exposures for children and pregnant women. A pilot project funded by a federal grant from the Environmental Protection Agency (EPA), SHEEP Project (Safe Home Environment for Every Pregnancy) was a pilot program that ended in 2009 that focused on implementing and evaluating a tool for screening hazardous home environments. The MCH Section and Public Health's Office of Environmental Toxicology are partnering to expand SHEEP screening to other county maternity case management programs.

Maternal Depression Prevention Initiative is a policy focus area that emerged as a top priority from Oregon's Maternal and Child Health (MCH) leadership retreat in 2008 and from the Oregon Legislature who passed HB 2666 in 2009. The initiative goals are to seeks to develop and implement a public health action plan to improve perinatal mental health and enhance systems and services for prevention, identification, treatment, and support of perinatal depression/anxiety. HB 2666 created a work group on Maternal Mental Health disorders (prenatal through one year postpartum) composed of public and private health and mental health providers and experts. The Maternal Mental Health Work group will submit recommendations to the Legislature by September, 2010, for effective, culturally competent, and accessible prevention, screening/ identification, and treatment strategies and evidence-based practices for health care providers and public health systems, including private and public funding models.

Capacity and Services For Young Children and Youth
The Office of Family Health implements the following programs and initiatives for children, youth, and adolescents.
Early Hearing Detection and Intervention Program facilitates Oregon's Newborn Hearing Screening legislation (ORS 433.321) which mandates that all infants born in facilities with 200 or less births be screened for hearing loss within 6 months of birth. The EHDI program supports parents of newly diagnosed infants with hearing loss, conducts a parent mentoring program (Guide By Your Side), disseminates EHDI program materials developed for parents, maintains a tracking and recall registry to ensure all infants are screened and receive necessary follow-up services. Participants in the EHDI registry include hospitals, diagnostic audiology centers and Early Intervention (Part C) programs who report individual-level results. Out-of-hospital births screening is provided through partnerships that provide free screening and enable the EHDI

program to purchase and loan out screening equipment. The program also continues to loan hearing screening equipment to Early Head Start programs for the purpose increasing the State's capacity to track late-onset or progressive hearing loss. The program receives federal support from the CDC grant for EHDI.

Babies First! Program is a public health nurse home visiting programs that provides primary and secondary prevention program in the home for infants and children up to age 5 and their families. Funded with state general funds and Targeted Case Management funds, county health department public health nurses provide assessment of the mother and infant attachment and the home environment, screening for developmental delays, vision and hearing, counseling, case management, advocacy and education, as well as referral and follow-up. The Babies First! Program is coordinated at the local level with CaCoon home visiting for children with special health needs, and Oregon Healthy Start administered by the Oregon Commissions on Children and Families. A New Framework for Oregon's Public Health Home Visiting System is being developed by state and local public health partners to reframe Oregon's home visiting system to include evidence based models suitable for statewide sustainability. A multi-agency workgroup is conducting a statewide and local capacity and population health needs assessment to satisfy new Title V requirements under the Early Childhood Home Visiting Program, passed by the Patient Protection and Affordable Care Act in 2010.

A pilot initiative to integrate a system of wellness, prevention, and treatment for children birth to age 8, is currently being implemented in two counties, supported by the LAUNCH (Linking Actions for Unmet Needs for Children's Health) grant initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA). LAUNCH is implementing evidence-based interventions across the lifespan, and evaluating for policy and program development.

The Oregon Child Care Health Consultation (CCHC) Program serves child care providers with technical assistance and consultation for health and mental health concerns and issues, 9 county regions. The CCHC goals are to improve knowledge of child care providers about practices that ensure health and healthy environments of facilities and enhance child health and safety policies in child care. Activities include consultation on health and safety in child care; on-site, assessment-based, comprehensive consultation; group training and community health events for child care providers, parents and children. Partners include the child care licensure agency and an advisory group, Child Care Health Links of partners from the primary care, mental health, and early care and education systems.

The Oral Health Program goals are to improve the oral health and prevent cavities and decay of children and adults by through statewide oral health systems infrastructure development, policy development for fluoridated community water systems, school-based sealant programs, school-based fluoride supplement program, and an early childhood cavities prevention program. Title V provides resources for public health dentist consultant and the school-based fluoride supplement program. Federal HRSA funds support the school-based dental sealant projects and the oral health infrastructure planning and implementation, from CDC. The Oral Health Program collaborates with the Oregon Oral Health Coalition and other partners to address oral health and its links to other chronic conditions. A new federal HRSA grant, First Tooth, will support training medical providers to screen young children for oral health needs through a new federal grant.

Infant and Child Nutrition Consultants provide consultation and leadership to build environments and public policies that increase nutrition and physical activity of infants, children and adolescents, and prevent obesity and overweight conditions. The Consultants promote the Breastfeeding Mother Friendly Employer laws; integrates nutrition into all existing MCH programs to increase support healthy eating, access to healthy foods, and physical activity; coordinates between MCH and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for healthy eating and breastfeeding; strengthens existing institutional nutrition services by ensuring services are provided by appropriately qualified personnel; and participates in assessment of the nutritional status of the MCH population. Nutrition Consultants provide

consultation and technical assistance to state and local MCH programs and partner with the Chronic Disease Section on mutual healthy living policies and activities, and participate with coalitions working to develop public policies that support good nutrition and physical activity.

Oregon's Early Childhood Comprehensive Systems (ECCS) Initiative coordinates integration of early childhood policies and strategies within existing activities and programs. The project works across and in collaboration with Title V programs in OFH and OCCYSHN and other agencies that participate in the Early Childhood Council. A Governor's Summit on Early Childhood, in March, 2008, launched " Early Childhood Matters: Oregon's Framework for A Birth through Five Early Childhood System." This framework has three core elements: Health Matters; Early Learning Matters; and Family Matters. The state ECCS Program co-chairs the Health Matters sub-committee. ECCS initiative facilitates a DHS workgroup is convened to work on common early childhood issues and policies and includes representatives from Children, Adults and Families Division -- foster care and child protective services, Addictions and Mental Health Division -- early childhood mental health program, and Division of Medical Assistance Programs (Medicaid/Oregon Health Plan).

WIC - Special Supplemental Nutrition Program for Women, Infants and Children is designed to improve health outcomes and influence lifetime nutrition and health behaviors in a targeted, at-risk population. The State WIC Program contracts with 34 local health agencies to provide WIC services to over 109,000 pregnant and postpartum women, infants, and preschool children each month in all geographical areas of the state. WIC contracts with farmers and farmers' markets to provide coupons to participants and partners with the Farm Direct Nutrition Program, Oregon Dept. of Agriculture, Oregon Seniors and People with Disabilities, Oregon Farmers' Market Association, and Oregon Food Bank. WIC's new Fruit & Veggie Voucher Program, Fresh Choices, provides WIC families with checks to purchase fresh, locally-grown fruits, vegetables and cut herbs directly from local farmers. The Oregon WIC data system, TWIST, provides important data to identify trends and risk factors to better target nutrition education and assistance to the WIC-eligible women, infant and child population.

Injury and Violence Prevention Section (IVPS), located in the Office of Disease Prevention and Epidemiology, Public Health Division, examines data that describe injury problems among Oregonians to identify prevention strategies, plan interventions and evaluate outcomes. The Child Injury Prevention Program, supported by Title V funds in the OFH, conducts education, technical assistance and information on injury topics to communities and groups in Oregon; trains local health department staff as certified safety seat technicians; and supports local capacity development to deliver safety seat clinics and distribute safety seats. The Oregon SAFE KIDS Coalition includes public and private organizations including emergency responders, law enforcement, health and safety professionals as well as interested citizens who work together to reduce unintentional preventable injury and death in Oregon's children Ages birth to 14. Nine chapters and five local coalitions geographically represent Safe Kids Oregon, reaching approximately 85% of Oregon's children under the age of 14. Also in IVPS, the Youth Suicide Prevention Program collaborates with the Adolescent Health Section in OFH to develop and implement the Statewide Youth Suicide Prevention Plan. The Plan includes 15 strategies for state and community-based action require a commitment to partnership and shared responsibility among state agencies, between state and local governments, and between public and private sectors. IVPS also implements an Intimate Partner Violence Surveillance Project develops and maintains a statewide IPV data collection system that helps to determine statewide IPV incidence and prevalence, estimates and identifies the risk and protective factors associated with IPV, and helps guide program design and policies in partnership with the OFH Women's Health Program.

Capacity and Services For Older Youth and Adolescents
The Adolescent Health Section aims to maximize the health and functioning of Oregon's adolescent population, and it includes the Oregon Genomics Program. Title V funds support leadership and policy development activities at the state level, health promotion activities and infrastructure development in county health departments, and ongoing assessment, data

collection and technical assistance for implementing statewide policies and programs related to adolescent health at the local level. The Teen Pregnancy Prevention/Adolescent Sexual Health Partnership (TPP/SHP) is a coalition of state, county and community advocates and non-profit organizations. This group coordinates and implements the Oregon Youth Sexual Health Plan, a holistic action plan to address all aspects of youth sexual health, built on a foundation of scientific evidence, findings of current health and youth development research, Oregon youth-lead research, and community forums. The Plan emphasizes collective responsibility to provide youth with accurate information and skill-building opportunities so that they may chose behaviors that nurture healthy relationships, prevent unwanted pregnancies and decrease risk of sexually transmitted infections.

School Based Health Center (SBHC) Program administers Oregon's 54 School-Based Health Centers (SBHCs) as a unique health care model in which comprehensive physical, mental and preventive health services are provided to youth and adolescents in a school setting. SBHCs see children who otherwise would not get care; help students get back to the classroom faster; lessen the demand on parents to take time off to get children to well and urgent care needs, and improves students' health. The Healthy Kids Learn Better (HKLB) Program (Coordinated School Health model) is a statewide initiative to help local schools and communities form partnerships and reduce physical, social and emotional barriers to learning. HKLB works to reduce barriers to learning by promoting connections between health and education; building supportive funding, leadership and policy through implementation of the Coordinated School Health Blueprint for Action; providing technical assistance to local school districts on forming Healthy Kids Learn Better Teams, assessing their local needs and developing a Coordinated School Health Approach; training teachers on research-based health and prevention curricula; providing assistance on building and selecting comprehensive health education programs that work. There are about 60 HKLB sites in Oregon.

Oregon's Genomics Program mission is to promote the health and well-being of individuals and families who are impacted by inherited conditions or birth defects through public health assessment, policy development, assurance, and collaboration. The goals of the program are to reduce morbidity and mortality from inherited conditions and birth defects, to improve the quality of life for individuals and families impacted by inherited conditions and birth defects, and to empower people to make informed decisions about genetics and health.

The Immunization Section aims to prevent and mitigate vaccine preventable disease for all Oregonians. Activities include surveillance, outreach and social marketing, vaccines, registry, education, technical assistance and quality improvement for providers. Immunization ALERT is a statewide immunization information system that collects immunization data from public and private health care providers and links the data to provide accurate and up-to-date records. The Vaccines for Children Program (VFC) supplies federally purchased vaccines for immunizing eligible children in public and private practices, at no cost to participating health care providers. Oregon Partnership to Immunize Children (OPIC) is a public and private partner collaboration that advises on policies and programs to ensure Oregon's children are protected against vaccine-preventable diseases. The Oregon Adult Immunization Coalition, a statewide network of health and community partners, promotes prevention and control of vaccine-preventable disease through immunization of adults in Oregon and Southwest Washington.

Capacity and Services For Children and Youth with Special Health Needs
Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) ensures a statewide system of services reflecting comprehensive, community-based, coordinated and culturally competent family-centered care. The CaCoon (Care Coordination) Program provides specially trained public health nurses who help families and children develop management skills (e.g. feeding an infant with cleft lip/palate); connect with health professionals and families to identify needs, gather resource information and refer to appropriate services; and participate on community planning groups. The Community Connections Network (CCN) is a community team

process that seeks to improve local care and services for children and young adults to age 21 with chronic conditions or disabilities. Teams are located in 10 communities across Oregon. The team is made up of the family and local health care, education and social service providers, and on some teams, family liaisons who are involved in supporting the needs of the child and family. The teams and families work together, respecting the family's expert knowledge of their child's needs, family culture, values and beliefs. Children can be referred to the Community Connections Network team by families, the school, the family doctor, therapists, counselors or public health nurses. The Family Involvement Network (FIN) promotes opportunities for families and professionals to learn, support and nurture each other as equal partners. FIN provides education for medical and other professionals on the value of partnering with families and support for families engaged in a variety of program and health policy activities; and Family Liaisons. The FIN statewide network of CYSHN families provides parent perspectives, supports to CCN teams, trains parents on working with health professionals and on multi-disciplinary teams. Evaluation and epidemiology consultation is provided within OCCYSHN, with occasional technical assistance from the Child and Adolescent Health Measurement Initiative (CAHMI) and the Office of Program Evaluation and Research both conveniently located at OHSU within CDRC. The consultation adds capacity to OCCYSHN to support program, continuous improvement monitoring, and CYSHN population health monitoring. OCCYSHN also partners with the Oregon Office on Disability and Health in relation to its support and analysis of the BRFFS and Oregon Health Teen Surveys.

OCCYSHN and the Child Development and Rehabilitation Center (CDRC) have integrated CDRC's clinical activities with OCCYSHN's public health activities to benefit children with disabilities and complex conditions throughout Oregon. The integration will improve efficiencies in policy, systems of care, provider and parent preparation in the care of CYSHN. Areas of the integrated clinical and public health program include emphasis on care coordination, behavioral health, medical consultation in developmental pediatrics with specialty emphasis on autism, genetics and high risk infant care and follow-up. Activities that are clinic based are leveraged to provide community-based outreach clinics to better meet the needs of CYSHN at the local level. The integration of clinical activities allows OCCYSHN to draw on clinician expertise from a variety of specialties including speech, PT, OT, metabolic, genetic, craniofacial, spina bifida, neuro-developmental, child development and autism to better serve children and their families.

The Oregon Institute of Developmental Disabilities, a University Center for Excellence in Disability and Development (UCEDD), houses the Leadership Excellence in Neuro-developmental Disabilities (LEND) training program, the Oregon Office on Disability and Health (OODH), and the Center on Self Determination (CSD). The UCEDD builds capacity of communities by working with people with disabilities, families, state and local agencies, and community providers on projects that provide training, technical assistance, service, research, and information sharing. The co-location and coordination of UCEDD with the Title V CSHCN program strengthens its capacity to address the needs of children with special health needs and their families. OCCYSHN's partnership with LEND is strengthened by incorporating the community-based programs as training sites for trainees. LEND trainees regularly participate in Title V activities, including direct clinical services in CCN clinics, making referrals to CaCoon nurses, and consulting with nursing staff about the clinical problems of individual children. The OODH supports activities to improve the health and wellness of people with disabilities. The Center on Self Determination identifies, develops, validates and communicates policies that promote the self-determination of people with disabilities.

Cultural Competency Policies and Programs

The Oregon Title V Program at OFH and OCCYSHN recognize the significant disparities and inequities that exist for residents around health care access and utilization. Oregon's diverse populations are defined by rural and frontier areas, race and ethnicity, language, and socio-economic status. To address inequities and disparities, the Office of Family Health surveillance and program planning include engaging diverse communities for input on issues, analyzing

datasets for disparity issues and trends, and identifying evidence-based interventions and best practices in policies and programs to reduce inequities and disparities.

The Office of Multicultural Health and Services (OMHS), in DHS, adds capacity to MCH programs by providing technical assistance, consultation, and education in addressing cultural issues in health delivery and services. OMHS works with state and local government and community partners to improve health and human services programs and policies for underrepresented populations in Oregon through culturally specific and culturally competent approaches. The Office of Multicultural Health and Services also supports affirmative action, cultural competency and diversity initiatives that create and sustain welcoming environments that are inclusive and respectful of staff, customers and partners. The Oregon Health Care Interpreting Program was created by the 2009 Legislature to create a certification and registry program to assure the persons with limited English proficiency (LEP) are not excluded from medical, dental or mental health care based on inaccurate or incomplete information. OMHS, administers the health care interpreter certification laws and supports the Oregon Health Interpreter Council was also created to establish education, qualification standards for health care interpreters.

CDRC has been active with the National Center on Cultural Competency to increase the cultural competency of its staff in the provision of services to families of CYSHN. OCCYSHN also promotes cultural competency on CCN community teams and has worked to include cultural diversity in training and hiring of Family Liaisons (past years).

C. Organizational Structure

Oregon is one of several states in which the Title V Program is administered by two separate agencies. The designated Title V Agency is the Office of Family Health (OFH) in the Public Health Division, Department of Human Services (DHS). The Director of DHS is appointed by the Governor and sits on the Governor's Cabinet. DHS will separate into social services under DHS and a new organization the Oregon Health Authority effective 2011 (see below on this change); the OHA Director will sit on the Governor's cabinet. Oregon Health and Science University, under Oregon statutes 444.010, 444.020 and 444.030, is the designated entity to administer services for disabled children with authority to administer services for children with special health needs. The Title V CSHN services are administered through the Child Development and Rehabilitation Center (CDRC), an independent division at OHSU, by the Oregon Center for Children and Youth with Special Health Needs. DHS has fiscal responsibility for the Block Grant, and transfers 30% of total funds required for children with special health care needs to OHSU.

The Oregon Title V Director is Katherine J. Bradley, RN, PhD, Administrator of the Office of Family Health. Melvin Kohn, MD, is the Director for the Public Health Division and State Health Officer. Bruce Goldberg, MD, is the Director of DHS and a member of the Governor's cabinet. OFH employs 217 staff and199.76 FTE. Information about the OFH is found at http://www.oregon.gov/DHS/ph/ofhs/index.shtml.

The Title V CSHCN Director is Marilyn Sue Hartzell, M.Ed., Director of the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). She reports to Charles Drum MPA, JD, PhD, the Assistant Director of CDRC for Public Health, Community Outreach and Policy. Brian Rogers, MD, Director of CDRC, has executive oversight for OCCYSHN. As of July 2010, CDRC and its clinics and programs has been moved from the oversight of the Vice-Provost to the Dean of the School of Medicine, Mark Richardson, MD, MScB, MBA. Robert Nickel, MD, a CDRC developmental pediatrician, serves as OCCYSHN Medical Consultant. At present, 23 staff (9.02FTE) work for the OCCYSHN Title V office at CDRC, including the community-based Family Liaisons who are employees of OCCYSHN. Information about OCCYSHN is at http://www.ohsu.edu/cdrc/oscshn/.

New Oregon Health Authority

In 2009, the Oregon Legislature passed HB 2009 to create the Oregon Health Authority (OHA), set to open in July 2011. The OHA changes DHS so that social services programs for children, seniors, and disabilities remain in DHS and most health-related programs in the state will be joined together to form the Health Authority. The OHA will be overseen by a nine-member, citizen-led board called the Oregon Health Policy Board, appointed by the Governor and confirmed by the Senate. In the public sector, the OHA will consolidate most of the state's health care programs, including Public Health, Addiction and Mental Health, Division of Medical Assistance Programs (Medicaid-Oregon Health Plan), HealthyKids (Oregon Health Plan coverage for all children), Public Employee Benefit Board (state employee benefits), and Private Health Partnerships. The OHA will give the state greater purchasing and market power and will be working to improve how health care is delivered, reduce health disparities, and broaden the state's public health focus as well. For public health and MCH programs and services, this change is viewed positive for improving system coordination and collaboration that is always cited as a need or weakness of MCH systems and supports. The overall OHA organizational structure is in the attached brochure.

Office of Family Health
The Office of Family Health consists of sections that administer statewide programs and local contracts for services across the life course of MCH populations. OFH programs range from preconception through adolescence and young adults, and program staff are leading and participating in needs assessment, policy development, program implementation and evaluation, epidemiology and research, consultation and technical assistance to local agencies. The current organization structure for the OFH follows.

OFH Administration includes office business and fiscal services and MCH support services, which include the Title V and Family Health Projects Manager, Early Childhood Comprehensive Systems (ECCS) Grant, Medical Consultant, MCH Informatics manager, MCH Epidemiologist, and Dental Health Officer.

FamilyNet/Orchids is the statewide client data system linking MCH client data through the Oregon CHildrens Information Data System; and development of an MCH-Public Health Informatics system.

Maternal and Child Health includes programs, local services, and assessment and evaluation from pregnancy through children up to nine years of age, including oral health for all populations.
-- Perinatal Health: Maternity Case Management, Oregon MothersCare enrollment and outreach, Maternal Depression Task Force (HB 2666); PRAMS; Environmental ??? (EPA).
-- Infants and children to age 9: Babies First! High risk infant/public health nurse home visiting; EHDI-Early Hearing Detection and Intervention (HRSA), LAUNCH grant (SAMSHA); CHIPRA Outreach Grant (CMS); breastfeeding promotion; child care consultation; public health nurse consultation with local health departments and tribal governments, nutrition and physical activity promotion;
-- Oral Health Programs: Oral Health Systems Improvement Project, State Oral Health Plan, Sealant Program, fluoride supplement program, early childhood cavity prevention project, Smile Survey; "First Tooth" Workforce Development grant (HRSA); Oregon Oral Health Coalition.
-- MCH Assessment and Evaluation Unit: MCH Epidemiology; Title V and MCH needs assessment; MCH program evaluation; PRAMS and PRAMS-2; data analysis and updates.

Adolescent Health and Genetics includes: Adolescent health promotion and policy development; School-Based Health Centers; Coordinated School Health Program; Teen Pregnancy Prevention consultation; Healthy Teen Survey (Oregon's YRBS); nutrition and physical activity consultation.
-- Genetics Program includes public health genomics planning and implementation, family history project.

Women's and Reproductive Health Section includes women's health, family planning, and breast and cervical cancer screening.

-- The Women's Health Programs sexual violence prevention through Rape Prevention Education; Fetal Alcohol Syndrome prevention through surveillance; chronic disease reduction through health screening via the WISEWOMAN (Well-integrated Screening and Evaluation for Women Across the Nation -- CDC) Program; Women's Health Network is a statewide coalition focused on advocacy, education, research, and networking, and promotion of healthy choices for women before they conceive to ensure healthy pregnancies.
-- Family Planning programs Title X Family Planning (HRSA), Family Planning Expansion Project (Medicaid waiver).
-- Oregon Breast and Cervical Cancer Program helps low-income, uninsured, and medically underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. (CDC, Susan G. Komen for the Cure Oregon and SW Washington Affiliate, and the American Cancer Society).

Immunization Program includes the Provider Services and Vaccines for Children, ALERT Immunization Registry, IRIS client data system, School Law and forecasting, research and training services.

Nutrition and Health Screening (WIC) includes Nutrition Education and Supplemental Food Program, Farmers Market, Senior Farmers Market, Breastfeeding Promotion, and demonstration projects such as Peer Counseling for Breastfeeding and Five-A-Day Fruits and Vegetables promotion; TWIST client data system and analysis.

Oregon Center for Children and Youth with Special Health Needs
OCCYSHN consists of two community-based programs for CYSHN at the local level, family support program, family involvement network, assessment and program evaluation, and special projects, grants or initiatives, such as the Medical Home Initiative currently underway. Community-based programs include:
-- CaCoon -- The Oregon Care Coordination Program is a public health nurse home visiting program providing care coordination in every Oregon county through the local health departments, and
-- CCN -- Community Connections Network supports community-based interdisciplinary teams 10 mostly sites which bring together the resources and services to serve referred children with complex unresolved issues and their families.
-- FIN -- Family Involvement Network and services links and trains families of CYSHN with the CCN teams to serve as Family Liaisons.
-- FSP- Family Support Program currently administers administers the distribution of the Sidney and Lillian Zetosch charitable fund, which supports the purchase of adaptive equipment to help children with disabilities become successful in school.

OCCYSHN coordinates these services and links families to programs and services provided at the CDRC. OCCYSHN conducts assessment and program evaluation activities. The CDRC provides a variety of tertiary care clinics in both Portland and Eugene, geographically center of Oregon as well as regional outreach clinics in the state. Clinics are housed in Doernbecher Children's Hospital in Portland and at the Regional Service Center in Eugene in conjunction with the University Center of Excellence in Developmental Disabilities (UCEDD) at the University of Oregon.

Attached are organizational charts for Office of Family Health, Oregon Center for Children and Youth with Special Health Needs, and the relationship of both to the Governor.

An attachment is included in this section.

D. Other MCH Capacity

The Oregon Title V Director is Katherine J. Bradley, RN, PhD and the Oregon CYSHN Title V Director is Marilyn Sue Hartzell, M.Ed. Dr. Bradley has over 35 years experience in the health field working in nursing, research, and hospital administration before coming to the Title V Agency in 2004. She has a Ph.D. in nursing and health care outcomes management and research. Ms. Hartzell, M.Ed., has 35 years of experience working with and for programs supporting children with special needs and their families, as well as experience with policy and program development to support effective services to CYSHN. She has extensive experience developing and implementing evaluations of programs serving children with special health needs as well as doctoral work in public administration and policy.

In the Office of Family Health, each section is staffed with many years experience in public health program planning, implementation, and evaluation, and includes research analysts to evaluate data from a variety of data sources; most staff has graduate or doctoral level degrees in public health, health policy, public administration or medical or dental professional degrees. Professional consultants, section managers, and administration positions report to the Title V Director. Consultants include the MCH Medical Epidemiologist, Medical Family Practice Consultant, Early Childhood Mental Health Consultant, MCH Informatics, and MCH Program Specialist. The Child Injury Prevention Coordinator is supported with Title V funds and is located in the Injury Prevention Program, in the Office of Disease Prevention and Epidemiology, within the Public Health Division. The Injury Prevention Program also conducts research and surveillance of intimate partner violence, working in partnership with the OFH Women's Health Program.

The Office of Family Health employs approximately 220 permanent and temporary staff, with expertise and skills in all program areas. The direct delivery of MCH programs is provided by staff at local health departments, funded by Title V and other federal and state funds through grants to counties. There are approximately 2,000 county public health staff persons in Oregon, not including staff at non-profit or tribal health centers. This includes 34 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professional staff in Oregon LHDs. The Office coordinates the OFH local Agency Review process on a three-year on-site cycle to provide consultation for local public health services. A parent consultant is currently working with the Early Hearing Detection Intervention program to assist with parent perspectives in screening and referring infants.

Office of Family Health supports local Title V Programs that are delivered though county health departments through intergovernmental contracts. Counties develop annual program plans for MCH, Family Planning, Immunization and WIC. Program policies and resource issues are negotiated through the Conference of Local Health Officials, and the MCH Committee. Other advisory groups partnering with OFH programs to develop policies and programs include: Health Matters Early Childhood Committee, Oral Health Advisory Committee, WIC Advisory Committee, Oregon Partners to Immunize Children, Immunization Advisory Committee, Genetics Advisory Committee, Teen Pregnancy Prevention Task Force, FamilyNet Advisory Committee.

The Oregon Health Authority Director is Dr. Bruce Goldberg, appointed by Governor Ted Kulongoski to lead the formation of the Health Authority. Dr. Goldberg is the current director of the Oregon Department of Human Services (DHS). He will simultaneously serve as leader of both agencies during the transition, which will be complete by July, 2011.

The Oregon Children and Youth with Special Needs staff has expertise in public health nursing, developmental pediatrics, special education, community engagement and development, family involvement and family professional partnerships, rehabilitation services, health policy and evaluation and assessment. The Center is comprised of 4 core program activities: the Community Connections Network (CCN), the CaCoon Program, the Family Support Program (FSP) and the Family Involvement Network (FIN). Currently OCCYSHN has 23 staff (9.02 FTE), including the community-based Family Liaisons employees. Staff includes 1.0 FTE Policy and Systems Specialist to support and coordination to the policy, planning and evaluation of OCCYSHN's programs as well as special projects. OCCYSHN has a contract with an outside Evaluation and

Research Consultant (0.2 FTE) to provide consultation and coordination for OCCYSHN's evaluation and research activities and maintains an ongoing relationship with the CDRC Office of Program Evaluation and Research for additional needed evaluation and research services. The OCCYSHN program purchases access to and reports from the state ORCHIDs data system (described below) to support its monitoring and evaluation of the CaCoon program.

Activities that integrate public health activities and perspective into CDRC clinical activities receive support from OCCYSHN. Areas of focus are behavioral health, care coordination, medical consultation with an emphasis on autism spectrum disorders, genetics and high risk infant care and care coordination and feeding and nutrition. This effort has increased outreach to healthcare providers, families, educators and other professionals in rural communities through consultation and training by developmental pediatricians, behavioral psychologists, and pediatric nurse practitioners, and other clinical specialists as well as care coordination; ongoing consultation and support of families and their children around complex genetic issues, outreach to the Hispanic community to increase their access to necessary services, follow-up on children discharged from the NICU; and outreach to rural Oregon communities with specialty clinics.

OCCYSHN continues to seek out family input and perspective in project management, grant planning and evaluation, administration of gift funds and as consultant to grants, other projects and training initiatives. Through the Family Involvement Network (FIN), there is currently one family member working to manage and assist the program with a parent perspective to enhance connections throughout the state with parents of CYSHN, and to assist and arrange for training opportunities for both families and professionals. The state Family Voices coordinator is the parent coordinator of FIN. OCCYSHN continues to make family professional partnerships a high priority through the expansion and support of family liaisons and family involvement initiatives. Family members are staffing other programs with CDRC and as trainees in the LEND program. These family members provide additional family perspective on specific OCCYSHN projects and efforts, such as providing support to the Oregon Commission on Autism Spectrum Disorders and with the LEND program.

Oregon's SSDI (State Systems Development Initiative) supports the MCH Informatics (MCHI) Unit, in addition to other funding sources. They are creating a shared, standardized repository of information in a web-based data warehouse, along with tools that enable users to access, manipulate and analyze the data. The MCHI is working with Public Health Informatics on developing Health Information Exchange (HIE) system across Oregon, which is housed in the Oregon Health Authority (DHS) across all divisions. The Child Health Profile, which consolidates cross-program information about a child into a single view, is currently in development and is expected to help improve services, enhance user experience, reduce overhead costs, and improve MCH population health.

ORCHIDS -- the Oregon Child Health Information Data System -- is a local client data system that captures key performance and outcome measures for MCH home visiting and OCCYSHN programs statewide. All ORCHIDS data goes into the data warehouse for the purpose of reporting and analysis. All county programs input data into ORCHIDS locally, except for Multnomah County (Oregon's largest metropolitan county). Work is underway to import ORCHIDS data electronically from the Electronic Health Record (EHR) used by Multnomah County clinics.

MCHI established data sharing agreements and governance for the Child Health Profile, including data from Immunization, WIC, MCH, and CaCoon program services. Data sharing agreements supported inclusion of data from Early Intervention Services in the Dept. of Education to be included in the Child Health Profile. The data warehouse receives and validates data from EHDI, ORCHIDS, WIC, Oregon Vital Events Registration System (OVERS), and Oregon Childhood Blood Lead Poisoning Prevention programs to build Child Health Profile knowledge base.

MCH Assessment and Evaluation Unit includes program evaluation, epidemiology, survey

management, and data analysis.

An attachment is included in this section.

E. State Agency Coordination

State Title V Programs in the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) and the Office of Family Health (OFH) value collaboration and coordination among partners, stakeholders, and between their respective programs. With the Title V programs in two different agencies, the effort to coordinate and cross-communicate regarding common stakeholders and partners and common endeavors is a high priority to both programs. The new Oregon Health Authority will provide significant opportunities for leveraging the Title V priority issues across state health and mental programs as well as health plans and managed care organizations. Collaborations and partnerships with social service agencies will continue, with attention to sustaining partnerships as the agencies move to different oversights.

Title V has collaborative relationships with the federal programs housed in the Public Health Division, Addictions and Mental Health Division, and the Division of Medical Assistance Programs (Medicaid agency), as well as social service providers such as the Division for Children, Adults and Families and Commission for Children and Families. Each of these divisions uses state and federal funds to implement initiatives that link individuals to care, improve quality of care, promote behaviors and actions that reduce risk and improve health outcomes, and improve efficiencies in delivering public services and health care. Contacts or liaisons with expertise in MCH issues and services are available for Title V programs to engage in the course of policy development and analysis, program development and delivery, and participation in public and community work groups or meetings focusing on issues.

A) Title V Relationship with State and Local Agencies

Social Service Services Agencies: The state social service programs in Oregon are delivered through the Department of Human Services and the Oregon Department of Education. OFH-Title V partners and coordinates with these programs extensively at the state level through shared leadership and participation around policies affecting MCH populations across the state. The Public Health Director sits on the DHS cabinet with directors from social service divisions. DHS agencies include Oregon's Self-Sufficiency and child protective services are administered by the Children, Adult and Families Division (CAF). CAF includes programs such as TANF, SNAP, teen pregnancy prevention, Social Services Block Grant, child protective services, foster care, and adoption services. the Seniors and People with Disabilities Division, where programs include long term care licensing, senior programs, Disabilities Determination Unit, and Vocational Rehabilitation. Locally, MCH and family support services are coordinated directly with the local DHS offices, and in smaller counties, health and social services may be co-located for better services.

Early Childhood Systems: Oregon's Early Childhood Comprehensive Systems (ECCS) Project is collaborating with social service agencies to increase coordination across state social and health programs and is implemented through the Office of Family Health, and supervised by the Title V Director. The ECCS Project Manager, Title V Agency Director and the Title V CSYSHN Director are active participants on the Governor's Early Childhood Council. The Council is a public-private coalition of early childhood service agencies, providers, and stakeholders that includes three committees -- Health Matters, Education Matters, and Family Matters. Membership includes the Oregon Pediatric Society, the Oregon Department of Education, Head Start, Child Protective Services, and advocates for child health and well being. Each committee has identified priority issues and their work monitors and coordinates the many initiatives and activities across the state addressing their priorities. The ECCS Project Manager is co-chair of the Health Matters Committee. The Health Matters Committee functions as the State Council on Young Childhood

Wellness for the LAUNCH grant project.

Adolescent Health Services: Title V programs collaborate and coordinate with programs in the Division of Mental Health and Addiction Services, Children, Adult and Families Division (for teen pregnancy prevention), and the Oregon Department of Education. Collaborative work is around the Mental Health Initiative in the Healthy Kids Learn Better Program (coordinated school health), teen sexuality and pregnancy prevention services and policy issues, and surveillance through teen behavioral health surveys.

Local Public Health Agencies: State Public Health Division works closely with local public health agencies across the range for promotion of public health and protection of health risks. OCCYSHN works with local public health agencies and communities through coordinated care networks linking families and children to services and supports. Both Title V Agencies provide formula grants for local services and support those grants with statewide training, technical assistance, and consultation year-round and on-site. State and local MCH public health nurse leaders, over the last four years, have met to identify leading needs and issues and to collaborate in planning and implementation of programs and services that work. These collaborations have resulted in action plans around perinatal depression, preconception health, oral health, unintentional injury, and physical activity and nutrition as well the expansion of care for CSHCN up to age 21. The priorities are included in the MCH Five-Year Needs Assessment.

Primary and Tertiary Care Services: Primary care programs and services that reach the MCH populations are administered by other offices in the Oregon Health Authority (OHA). The Title V program collaborates with the Primary Health Care Office (PHC) in the Health Policy and Research Office (OHA). This office, in collaboration with the Oregon Primary Care Association, has oversight of the Federally Qualified Health Centers (FQHCs) and community health clinics.

Coordination among CDRC Clinics includes tertiary care clinics in Eugene and Portland and outreach clinic sites in Medford, Klamath Falls and Roseburg. Interdisciplinary teams and individual clinicians provide diagnostic assessments, consultation, and management for children and youth with established or suspected disabilities. Some of the clinical programs are "unique" in the state such as the Metabolic program, and the services offered by other programs are partially duplicated at other centers. The clinical programs include the Metabolic, Genetic, Craniofacial, Spina Bifida, Neuro-developmental, Child Development and Autism programs. In 2009, 7,929 CYSHN received 20,680 services in these clinics. Relationships between the OCCYSHN and clinicians are critically important to the support provided to individual children and families. Joint quality improvement projects are conducted with the clinics and involved the specialists in needs assessment of direct services.

Health Professionals Education and Organizations: Title V Programs in both OCCYSHN and OFH have relationships and collaborations with leading statewide professional organizations. With the Oregon Pediatric Society (OPS), Title V has collaborated to improve the preventive child health visit with increased developmental screening and referrals for young children, increase medical home practice for CYSHN, and collaborate OPS Committee on Children with Disabilities (CCWD). Title V is also collaborating with OPS and the Child and Adolescent Health Measurement Initiative (CAHMI) to implement a child health Improvement Partnership, which will identify clinical quality improvement measures. Title V also works OB/GYN organizations and OHSU School of Nursing to work with Title V on the Maternal Depression initiative as well as family planning and women's health issues.

OCCSYHN and the Leadership Excellence in Neuro-developmental Disabilities (LEND) training program have a partnership to improve knowledge and skills in the health and health-related workforce through distance learning efforts. OCCYSHN partnered with LEND in linking a LEND developmental pediatric fellow with the rural Lincoln County Community Connections Network team to provide the specialty medical perspective on cases seen within CCN, as well as consultation and training to local primary care providers.

Oregon's Early Hearing Detection Intervention (EHDI) program collaborates with OHSU and professional organizations to address Oregon's shortage of pediatric audiologists. OHSU audiologists created a mentoring program for audiologists to provide pediatric audiology across the state to increase the capacity for diagnostic testing while serving the uninsured and rural communities.
Western States Genetic Services Collaborative (WSGSC): The WSGSC is a multi-state project to increase access to genetic services among states and territories including Alaska, California, Guam, Hawaii, Idaho, Oregon, and Washington. The project is a cooperative agreement between the Health Resources and Services Administration, Maternal and Child Health Bureau, Genetic Services Branch and Hawaii Department of Health. Activities aim to improve the health of children with disorders detected by the newborn screening blood test, birth defects and other genetic disorders. OCCYSHN's Public Health Genetics Specialist is Co-Director of WSGSC, with the Hawaii Dept. of Health. Activities include a pilot using telemedicine for genetics and metabolic specialty visits, developing outcomes for genetic services, identifying strategies to improve reimbursement for genetics services, and developing a portable medical record for children with genetic conditions.

B) Title V and Other Federal Programs

EPSDT: The federal Early Periodic Screening, Diagnosis, and Treatment services in Oregon is administered and implemented through DMAP (Medicaid agency) and its contractual arrangements with managed care and other providers. While there is not a distinct EPSDT program, the services are including in the Oregon Health Plan prevention guidelines and the prioritized list of services. Title V and its public health programs as well as the Early Intervention/Early Childhood Education (EI/ECSE) programs of the Oregon Department of Education coordinate with DMAP and health care providers, especially in relation to early screening, care coordination and some therapies. In 2010-11, Oregon is one of five states participating in ABCD-III, sponsored by the National Academy of State Health Policy and the commonwealth Fund to improve Oregon's system for medical home care coordination services. DMAP is the lead agency, sharing leadership with the Title V Agency, Oregon Pediatric Society, Early Intervention/Early Childhood Special Education (IDEA Part C), and the Child and Adolescent Health Measurement Initiative.

Related to EPSDT is the Early Hearing Diagnosis and Intervention Program (EHDI), established in the OFH and reports directly to the Title V Director. A multi-disciplinary advisory committee provides direction for the entire newborn hearing screening process in which both the OFH and OCCYSHN participate. EHDI and the CDRC collaborate to assure appropriate follow up for children with potential hearing loss.

Newborn Metabolic Screening is administered by the Public Health Laboratory provides screening to all infants born in Oregon. Newborn screening follow-up, program consultation, quality assurance and education are provided by the CDRC. Through this agreement, all infants suspected of having metabolic problems are referred to the CDRC for follow-up.

WIC, Family Planning, Head Start, Education Services: The Nutrition and Health Screening Program (WIC) is in the Office of Family Health, under the direction of the Title V Director. WIC collaborates and coordinates across public health on delivery of local WIC services, and provides training and technical assistance to local WIC offices to coordinate locally with Title V programs. Additionally, WIC and OFH infant child nutrition consultants collaborate and coordinate with federal CDC funded programs centered in the Office of Disease Prevention and Epidemiology for chronic disease prevention, particularly in implementing the State Plan on Nutrition and Physical Activity, Diabetes, Asthma, and Breast and Cervical Cancer. These partnerships result in policies and programs that address the MCH populations as well as the adult population that achieves a kind of life course approach to issues.

Education and Child Care Providers: Both OFH and OCCYSHN work together on issues that cross health and education include early intervention and Child Find, early Head Start, coordinated school health, adolescent transition, early referral from NICUs to community-based programs, and workforce training. Lead staff from OFH and OCCYSHN participates on the State Interagency Coordinating Council and OCCYSHN co-leads the CDRC-ODE Child Find subcommittee. Joint efforts with the Oregon Department of Education include revising established and probable risk categories for EI, reviewing screening tests/protocols, and reviewing an universal screening tool.

OCCYSHN participates in a collaborative effort with Head Start/Early Head Start to provide education and information to child care service providers regarding appropriate supports for children with disabilities and chronic health needs in early childhood settings.

Linkages with Title XIX and Oregon Health Plan: Title V programs have several projects and initiatives that coordinate with Medicaid and link the MCH population eligible to OHP coverage. In the Office of Family Health, Oregon's MothersCare is an initiative to link women to early prenatal care through coordination of referral systems such as the MCH state toll-free hotline (SafeNet) for pregnancy test sites, local health departments, Maternity Case Management, WIC and other agencies that provide prenatal services, and sites that assist with OHP enrollment.

Other collaborations between OFH and DMAP include outreach and assistance to undocumented and isolated families to enroll their eligible children in the Healthy Kids/Orego Health Plan. The Oral Health program in OFH collaborates with DMAP to implement state and federal preventive practices for enrolled children.

OCCYSHN and DMAP have an interagency agreement to address reimbursement rates for services provided at tertiary clinics. Committees formed by CDRC and OCCYSHN include the Medical Director and staff of DMAP to discuss policies and issues for CYSHN enrolled in the Oregon Health Plan.

Both Title V Agencies in Public Health and OCCYSHN regularly provide information and presentations to the medical, dental, and mental health directors of Oregon Health Plan managed care organizations, as well as the Quality Improvement Coordinators Work Group. The purpose of the presentations is to provide information on community services and linkages for referrals, recent public health prevention initiatives, and specific collaborations or performance improvement programs for implementation by providers of the OHP contractors.

Social Security, Disabilities Services and Family Support (CYSHN): The Child Development Rehabilitation Center (CDRC), Social Security Administration (SSA), and the Disability Determination Services (DDS) of Vocational Rehabilitation Division (VRD) educate providers about Childhood SSI eligibility, outreach to potentially eligible families, and ensure that families who apply for SSI receive information about available services. Representatives of VRD participate on the community teams around issues such as youth transition. VRD and SSA staff regularly participates in educational conferences sponsored by OCCYSHN and Title V.

The Title V OCCYSHN nurse consultants collaborate with NICUs and high risk nurseries for discharge planning and referrals to CaCoon home visiting nurses. The CDRC and Shriners Hospital collaborate on adolescent health transitioning and medical home issues and CDRC pediatricians regularly staff clinics at the Shriners Hospital. Shriners' care coordinators have participated in Title V OCCYSHN sponsored conferences.

Family Support Organizations: OCCYSHN partners with several family-based organizations. These partnerships bring critical perspectives and insight to state level policy and program development and implementation, and help to illuminate unmet needs of families of CYSHN. Family support organizations include Juntos Podemos,Northwest Down Syndrome Organization, Lifespan Respite, Family and Community Together (FACT), Parent to Parent Planning Group and

the Swindell's Family Resource Center in two Oregon communities. OCCYSHN's collaboration with Juntos Podemos, a family support organization for Latino families, has lead to increased referrals of Latino families to CCN and CaCoon and the development of family support groups for Latino families These organizations assist OCCYSHN and the Family Involvement Network (FIN) to identify families who can provide input and participate in projects, meetings, trainings, and planning efforts across the state. Oregon Family Voices frequently works with OCCSYHN to link parent consultants to activities and groups that are working to improve systems and services for CYSHN and their families. The Family Voices coordinator is also a staff member of OCCSYHN.

Oregon Commission on Autism Spectrum Disorder: OCCYSHN is highly involved in state efforts to improve services and the system of care for individuals with Autism Spectrum Disorders. OCCYSHN's medical consultant was selected to serve on the OCASD in 2008. Dr. Nickel also chaired the Health Services subcommittee and served on the Screening, Identification and Assessment subcommittee. OCCYSHN Director has interacted with the Community Services for Children and Families subcommittee. The partnership between the Commission and OCCYSHN led to submission of a grant request to assist in implementing components of the OCASD plan.

F. Health Systems Capacity Indicators

Introduction

Oregon's health systems capacity benefits from the linkages of systems at the state and local level. Program and policy work represented by these indicators are housed in the Oregon Healthy Authority and the Oregon Center for Children and Youth with Special Health Needs. Data for the indicators is therefore readily available to the Title V Program.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	15.1	14.8	14.1	14.1	14.1
Numerator	346	342	328	331	331
Denominator	229032	230908	232408	234168	234168
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Source: Asthma Program (http://www.oregon.gov/DHS/ph/asthma/)

Numerator: Hospital Discharge Data. Denominator: Oregon Population Research Center, 2008

data for 0-4 years of age. Excludes Oregonian cases hospitalized in 3 hospitals in Vancouver, WA, that were traditionalyl included in asthma rates in 2007 and prior. Final 2008 updated and carried forward. 2009 data currently not available.

Notes - 2008
Source:
Hospital Discharge data from Asthma Program.

Notes - 2007
Source:
Numerator: Hospital Discharge Data, 2007.
Denominator: Portland State Population Research Center, 2007 data.

Narrative:
Hospital discharge data are readily available from the Asthma Program. Numerator is based on count of asthma cases among children less than five years of age. Denominator is based on current population estimates from the Annual Oregon Population Report produced by the Oregon Population Research Center at Portland State University. At the present, 2009 hospitalization data is unavailable.

The rate of hospitalization for asthma among children less than five has steadily declined from a high of 18.1 per 10,000 children in 2004 to a low of 14.1/10,000 in 2008, remaining at 14.1/10,000 in both 2007 and 2008. Since 2004, the annual rate has been below the Healthy People 2010 target of 25.0. Prior to 2008, Oregon asthma cases included children hospitalizations in 3 hospitals in Vancouver, Washington, which might have contributed to the higher cases between 2004 and 2006. In general, factors that may influence asthma hospitalizations in children include environmental conditions (both indoor and outdoor), parent's ability to read and comprehend health information, secondhand smoke exposure, cultural differences, and access to care.

A report on Oregon children with asthma on Medicaid in 2004-2005 showed that for every 100 children under five with asthma, there was an average of over 6 hospitalizations for asthma a year. The highest rates for hospitalization in this report were in mostly rural counties. The Oregon Asthma Program works with Division of Medical Assistance Program contracted health plans to improve how health systems manage people living with asthma. Evidence based interventions with health plans focus on increasing use of controller medications by people with asthma, and ensuring that people who experience an asthma exacerbation that requires a trip to the emergency department receive follow up care from their primary care doctor to adjust their medication and self management goals in order to prevent future emergency department visits.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	92.4	92.7	90.8	89.7	89.7
Numerator	28594	30132	26723	22064	22064
Denominator	30945	32491	29434	24603	24603
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: DMAP.
2008 data is based on federal fiscal year (Oct. 1, 2007-Sept. 30,2008) due to reporting requirement of EPSDT.
Numerator: Total eligibles receiving at least one initial or periodic screening; Denominator: Total eligibles who should receive at least one initial or periodic screening.

Year 2009 DMAP data unavailable, 2008 data carried forward. In 2009, there was change in DMAP tracking system - switched to the MMIS system.

Notes - 2008
Division of Medical Assistance Programs (DMAP), Federal Fiscal Year (July 1 2007 - June 30 2008). Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Separate data for SCHIP is not consistently available. Data reported in previously was preliminary and based on state fiscal year (July 1 2007 - June 30 2008).

Notes - 2007
Source: Division of Medical Assistance Programs. Most recent data from CMS is 2006 . Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Narrative:
Medicaid data is readily available from the Division of Medical Assistance Programs. SCHIP data is rolled into Medicaid data as a seamless Oregon Health Plan (waiver) program. Data reported in the previous report was based on state fiscal year and was preliminary; final 2008 data that DMAP reported to EPSDT was obtained and updated, and is based on federal fiscal year -- EPSDT reporting time frame. Year 2009 data is currently unavailable due to implementation DMAP's new tracking system (Medicaid Management Information System (MMIS) on June 30, 2008.

The percent of Medicaid enrollees whose age is less than one who received at least one initial periodic screen has remained around 90% between 2005 (92.4%) to 2008 (89.7%).

The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) has initiated a Learning Collaborative around developmental screening in five counties that will provide information about the strategies and need for early and periodic screening. This project will also evaluate the reliability of data sources used to create the numerator and denominator of this measure. The new ABCD Learning Collaborative sponsored by National Academy of State Health Policy, in which Oregon is participating, will facilitate discussions and process to change how EPSDT is delivered and reported to the state.

The ABCD Learning Academy identified ways to track the utilization of standardized screening among Oregon Health Plan enrollees. An indicator was developed by the DMAP program to measure the rate per 10,000 children on OHP aged 6 months through 37 months old who received a developmental screen (96110 CPT code claim). Other ongoing efforts are to train pediatricians to integrate early developmental surveillance, screening and referral in their well-child visits.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	92.4	92.7	90.8	89.7	89.7
Numerator	28594	30132	26723	22064	22064
Denominator	30945	32491	29434	24603	24603
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: DMAP. Data not available consistently for SCHIP separately , so based on data for HSCI #02. 2009 data is currently unavailable.

In prior years, data has not been available separately for SCHIP. However, separate data for SCHIP recently became available. OFH-MCH plans to assess the feasibility of obtaining data for SCHIP separately; if data continuous to be available consistantly, MCH will review reporting method and update data in future reports.

Notes - 2008
Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid Waiver).

Notes - 2007
Source: Division of Medical Assitance Programs.

Narrative:
See HSCI #02. Separate data for SCHIP to report the EPSDT rates is inconsistently available, therefore interpretation is embedded in HSCI #02.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	68.1	68.3	67.5	70.5	73.4
Numerator	31270	33157	33122	33979	34023
Denominator	45904	48513	49058	48197	46327
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Oregon Center for Health Statistics (CHS)/Vital Statistics

New birth record system implemented in 2008, resulting in slight change in calculation method. 2008-09 data based CHS current new calculation method. Due to the change in tracking method, 2008 data will be used as a new baseline.

Notes - 2008
No 2008 data. Data carried forward from 2007. Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. Therefore, 2008 and 2009 data are not yet available. New birth certificate variables will be used to determine whether a pregnant woman had received "adequate prenatal care" or not. The new computation method has not yet been finalized.

Notes - 2007
Source: Oregon Center for Health Statistics. Data is final

Narrative:
The MCH Program has direct access to vital statistics data. Prior to 2008, MCH was able to calculate for the Kotelchuck indices relating to the amount and adequacy of prenatal care. Starting in 2008, Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth that does not have the same data on the Kotelchuck index as in 2007 and prior. A new computation method based on similar variables in the new birth certificate is used to obtain 2008 and 2009 data.

Based on existing data, the percent of women with a Kotelchuck Index of 80% or greatershowed a slight trend downward, from 70.0% in 2004 to 67.5% in 2007. However, 2008 data shows an increase in this measure (70.5%), and continues to increase in 2009 (73.4%). More accurate data on date of prenatal care initiation might have contributed to the increase.

With the new computation for 2008 and onward, the MCH program will investigate the validity of this new data by comparing with states that have used a similar computation method. The work group will consist of MCH and vital statistics staff, and partners from other states.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.8	80.8	77.5	71.6	71.6
Numerator	242966	242966	233317	233248	233248
Denominator	300870	300870	300870	325925	325925
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Source: DMAP
2009 data not available, 2008 data carried forward and is based on federal fiscal year.
Numerator: children 1-21 who received service paid by Medicaid during federal fiscal year Oct. 1, 2007-Sept. 30, 2008. Denominator: potentially eligible Medicaid children (1-21) from Oregon Population Research Center, with Medicaid's own popuation data for FPL adjusted to those under 200% FPL.

This measure is not included in the annual EPSDT report.

Notes - 2008
Numerator: Division of Medical Assistance Programs, State Fiscal Year (July 1 2007 - June 30 2008).

Denominator: Data from Population Research Center, adjusted to account for those under 200% of poverty.

Notes - 2007
Sources:
Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.
Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Narrative:
The data sources for this indicator are readily available from the Division of Medical Assistance Programs (DMAP) using the MMIS that was implemented in 2008; however data availability is delayed.

The percent of potentially Medicaid eligible children aged 1-21 years old who received a service paid for by Medicaid in 2008 was 71.6%. This is substantially lower than prior years, which ranged from a high of 80.8% (year 2006) to a low of 77.5% (year 2007). However, caution should be exercised when making comparisons across years as we are unable to determine whether the methods used for 2008 and the methods used for 2004-2007 are comparable. A log documenting how the prior queries were made is not available and staff turnover has occurred.

Despite the decreasing trend between 2007 and 2008, more children actual became eligible for Medicaid (about 25,000 more children). It appears that the increased amount of children eligible did enroll in Medicaid at some point in 2008.

Oregon's Healthy Kids initiative is expected to provide coverage for more children. Capacity to outreach potentially eligible children occurs through several linking mechanisms, such as SafeNet, the MCH Toll-Free hotline, local public health nursing programs, and Headstart and other child care programs. Application assistance is available for parents at county health departments and DHS Service Delivery Area.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	41.7	41.7	45.4	47.3	47.3
Numerator	22301	22301	23307	24013	24013
Denominator	53543	53543	51285	50747	50747

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: DMAP. Numerator: Total eligibles (ages 6-9 years of age) who received any dental service during the federal fiscal year via EPSDT report. 2009 data unavailable, 2008 data carried forward.

Notes - 2008
Division of Medical Assistance Programs, State Fiscal Year (July 1 2007 - June 30 2008).

Based on preliminary 2008 data. Final 2008 data is currently unavailable -- computation for final 2008 data is in progress and will be updated as it becomes available.

Notes - 2007
Sources:
Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.
Denominator = 2007 Population Projections for ages 0-19. Population Research Center, Portland State University, March 2008.

Narrative:
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year was 47.3% in 2008. This percentage is higher than prior years, which ranged from a low of 40.1% in 2004 to a high of 45.4% in 2007. However, caution should be exercised when making comparisons across years as we are unable to determine whether the methods used for 2008 and the methods used for 2004-2007 are comparable. A log documenting how the prior queries were made is not available and staff turnover has occurred.

This data represents those children aged 6 to 9 years who have received a dental service paid for by the Oregon Health Plan. Dental coverage for children has been increasingly reduced and outreach for enrollment continues to be limited due to budget restraints. Oregon's Oral Health Statewide Plan, along with a new broad Oral Health State Coalition, will be addressing many issues surrounding dental care for children in the next few years. The changes in the Oregon Health Plan, however, continue to cover dental services to families with up to 185% of the federal poverty level.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	33.8	23.5
Numerator	0	0	0	2569	1893
Denominator	6832	7077	7077	7593	8061
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
A reliable data source is not available for this measure. In the past, the list of children seen at the Child Development and Rehabilitation Center Clinic for rehabilitation services was compared to the list of children receiving SSI from Department of Human Services. This strategy is no longer possible because of time-restraints and HIPAA requirements. A proxy measure explored is the number of notices mailed to families regarding eligibility to CSHN program by the DHS-SSI office.

Notes - 2008
This marks the first year we are using a proxy measure to assess our progress with respect to this indicator. As described in the prior year's notes, we worked collaboratively with the Oregon Department of Human Services, Disability Determination Services (DDS), to provide a letter to families of children who applied for Supplemental Security Income (SSI) benefits. The content of this letter explains to families the availability of OCCYSHN community-based programs and services. DDS began sending this letter to families beginning FY2008 (July 1, 2007). The numerator for this indicator is equal to the total number of letters sent to families of children who were newly awarded SSI benefits (n = 1,594) and to families of children who were denied SSI benefits (n = 975). The source of the numerator value was provided by DDS. The denominator for this indicator is equal to the total number of children in Oregon under the age of 16 receiving Federally administered SSI payments as of December 2008 (n = 7,593). The source of the denominator value is the Social Security Administration Supplemental Security Record, "Table—Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2008".

Notes - 2007
OCCYSHN is exploring technical assistance to develop data sources for the numerator and denominator for Oregon. for this measure.

Narrative:
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program

In relation to this indicator, OCCYSHN has continued to use a proxy measure to assess its program. As described in the prior year's notes, OCCYSHN worked collaboratively with the Oregon Department of Human Services, Disability Determination Services (DDS), to provide a letter to families of children and youth who applied for Supplemental Security Income (SSI) benefits. The content of this letter explains to families the availability of OCCYSHN community based programs and services. DDS has been sending the letter to families since the beginning of FY2008. The numerator for this indicator is equal to the number of letter sent to families of children who were newly awarded SSI benefits (n= 1,893) and the number of letters sent to families of children who were denied SSI benefits (n= 1,233). The source of the numerator value was provided by DDS. The denominator for this indicator is equal to the number of children in Oregon under the age of 16 receiving federally administered SSI payments as of December 2009 (n= 8,061). The source of the denominator value is the Social Security Administration Supplemental Security Record, "Table --Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2009".

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	6.3	6.2	6.2

Narrative:
Birth certificate data on birth weight and payer is routinely available from the Oregon Center for Health Statistics.

In 2009, 6.3% of women with Medicaid insurance for their deliveries had low birth weight babies. 6.2% of women without Medicaid insurance for their deliveries had low birth weight babies.

Oregon currently has no program focused on decreaseing low birth weight either for Medicaid or non-Medicaid insured women. However, Oregon does have programs for smoking cessation in pregnant women, which may contribute to a decrease in the rate of low birth weight births. See Health Status Indicator 1B for more details.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	payment source from birth certificate	5.9	4.9	5.5

Narrative:
Birth certificate data on infant mortality and payer is routinely available from the Oregon Center for Health Statistics. However, 2006 is the most recent year for which matched infant death data is available.

In 2006, infant mortality among women with Medicaid insurance for their deliveries was 5.9/1000 live births.
Infant mortality among women without Medicaid insurance for their deliveries was 4.9/1000 live births.

This is not surprising, since Medicaid provides insurance for low socioeconomic status women.

Oregon's SIDS prevention program works through local health departments and is therefore likely to have the most impact on Medicaid-insured women.

About 40% of Oregon women are taking folic acid at the time they become pregnant. Public

health education campaigns are often targeted at low SES women but probably reach both low SES and high SES populations. Taking folic acid decreases the risk of neural tube defects including some, like anencephaly, that are fatal.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	59	80.8	71.5

Notes - 2011
Source: Oregon Center for Health Statistics.

Narrative:
Birth certificate data on prenatal care initiation and payer is routinely available from the Oregon Center for Health Statistics.

In 2009, 59.0% of women with Medicaid insurance for their deliveries initiated prenatal care in the first trimester.
80.8% of women without Medicaid insurance for their deliveries initiated prenatal care in the first trimester.

We are aware of a variety of barriers to Medicaid-eligible women getting enrolled in Medicaid and beginning prenatal care by the end of the first trimester of pregnancy. The Office of Family Health has a program, MothersCare, that can facilitate enrollment in Medicaid. Unfortunately, the 2005 Deficit Reduction Act increased barriers for many women, such as the need to present their birth certificates. The Oregon Center for Health Statistics has helped provide birth certificates for Oregon natives women, but some pregnant women have had their Medicaid enrollment delayed by the need to obtain an out-of-state birth certificate. In addition, Oregon does not have presumptive eligibility that would allow prenatal care providers to be reimbursed for care delivered to pregnant women even if they are later determined to not be eligible for Medicaid.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid,***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	payment source from birth certificate	65.8	79.2	73.4

Notes - 2011
Source: Oregon Center for Health Statistics
Provisional 2009 data obtained and entered. Based on new birth record system. See HSCI #4 for more detail.

Narrative:
The MCH Program has direct access to vital statistics data. Prior to 2008, MCH was able to calculate for the Kotelchuck indices relating to the amount and adequacy of prenatal care. Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. New birth certificate variables were used to determine whether a pregnant woman had received "adequate prenatal care" or not. A new computation method based on variables in the new birth certificate has not yet been finalized; however, provisional 2009 data has been obtained and updated.

The 2007 data show a substantial difference between women whose births were paid by Medicaid and those whose births were not paid by Medicaid. Some of this difference is probably due to the later initiation of prenatal care, which is discussed for Health Systems Capacity Indicator #05C.

In 2009, about 65.8 percent of pregnant women with a Kotelchuck Index of 80% or greater were on Medicaid. This showed a slight upward trend from 2007 (60.6%). However, the percentage of pregnant women with a Kotelchuck Index of 80% or greater on Medicaid continues to be lower than those with non-Medicaid insurances.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
Healthy Kids is a program of the Oregon Health Plan that mandates all eligible children will have health
insurance regardless of income. Healthy Kids offers three avenues of coverage: 1) Oregon Health Plan (OHP) Plus (Medicaid); 2) Employer Sponsored Insurance (ESI) insurance; or 3) Healthy KidsConnect, a private market insurance option.

Children in families earning 200% FPL or less will receive Healthy Kids coverage at no cost. Children in families between 200% and 300% FPL will receive a sliding scale subsidy for the cost of their premium.

Healthy KidsConnect (HKC) plan is a private insurance option. Children in families with eligible uninsured children between 201% through 300% FPL can receive a premium subsidy for insurance carriers contracted in the HKC program. Uninsured children above 300% FPL can purchase coverage through the HKC program by paying the full premium cost.

For the Employer Sponsored Insurance (ESI) component, those families who are at 300 % FPL or higher can receive premium assistance in the form of a reimbursement, as long as the employer plan meets federal guidelines.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	200

Narrative:
See HSCI # 6A Narrative

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	185

Narrative:
The Division of Medical Assistance Programs (DMAP) administers the Oregon Health Plan. Currently, most adults, aged 19-64 with incomes up to 100% FPL are eligible for OHP Standard, for which there is a waiting list. Pregnant women and persons with disabilities with incomes up to

185% FPL are eligible for OHP Plus. Oregon does not have a presumptive eligibility law for pregnant women. OHP Plus includes Oregon's SCHIP program, now called "Healthy Kids," which covers children up to age 19, who have or are in families with incomes up to 200% FPL, with subsidies for co-pays and/or premiums for employer plans.

To increase access to early prenatal care, DMAP implemented a pilot program in two counties to provide prenatal care to women who do not have access to these services under a traditional Medicaid program. State/county partnerships were established to put together the required financial match to acquire federal SCHIP funds for the project: 73 percent federal funds, 25 percent state funds, and 2 percent county funds. The pilot was for pregnant women residing in Multnomah (urban) or Deschutes (rural) Counties who are not eligible for any Medical Assistance coverage other than CAWEM (Citizen-Alien Waived Emergent Medical), such as undocumented immigrants, or immigrants with documentation who have not completed their five year US residency requirement. When the pregnancy ends, the mother returns to regular CAWEM status and the newborn child will be covered for up to a year before eligibility will be re-determined. The CAWEM prenatal care project is expanding to up to 7-10 more counties in 2010.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The Office of Family Health in the Oregon Health Authority has direct access to most data sources. However, efforts over several years to initiate a birth defects surveillance system has not achieved that goal. Oregon has both a PRAMS surveillance system and a self-funded PRAMS-2 longitudinal survey of mothers with 2 year old childre.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes

Notes - 2011

Narrative:
Oregon does not have the CDC-YRBS, but instead implements the Oregon Healthy Teen survey, with questions on tobacco use.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Priorities were selected using a multiple step process engaging stakeholders, interested persons, evaluating data sources, and brainstorming program activities. Strategic planning for all the priority areas will be forthcoming in the first half of the year. Most activities will be focused on more in-depth assessment, partnership-building, planning activities within the Title V roles and responsibilities, and determining areas for systems building. In each area, the Title V Offices are committed to assess and plan work to reduce disparities and inequities related to each priority area. Performance measures were selected based on available data sources or process data that will be created during the planning stage and reflect, as much as possible, the work feasible for the Title V Offices.

2011 Priority Unmet needs

1. Family Violence -- Family violence, including intimate partner violence and child abuse

2. Alcohol and Drug Use -- Drug and alcohol abuse, including accessibility of services (and prevention of Fetal Alcohol Syndrome)

3. Mental Health -- Mental health, including accessibility of services

4. Oral Health -- Oral health and early childhood cavities prevention, including accessibility of services

5. Resources for Parent Education and Skills -- Parents' resources and parenting behaviors (including parenting education and other support services) to support young children's health, development, safety, and social-emotional health

6. Overweight and Obesity -- Prevent and address overweight and obesity in older children and adolescents, including nutrition, food security, physical activity and screen time

7. Physical and Mental Health Services Access -- Access to preventive physical and mental health services

8. Linkages for CYSHN to Mental Health Services -- Lack of linkages or referral pathways to appropriate mental health services for children and youth with special health need

9. Access to Specialized Services -- Limited access to specialized health and related services (specialty care, mental health, PT/OT, etc.) for children and youth with special health needs particularly in rural and frontier areas

10. Access to Family Support Services -- Families and providers lack knowledge and awareness of support services available for families of children and youth with special health need
amily support needs)

B. State Priorities

In the Oregon assessment, the selection of priorities evolved over the course of the assessment with input from surveys and from stakeholder engagement. As some of the priority areas were pertinent to more than one population group, the Leadership Team determined to select one population group to focus that priority need. With the phased survey and prioritization methods, the selection of the priority health needs was straightforward. The Title V Leadership Team reviewed the summary report prepared by the assessment team, consulted the needs and priorities collected from stakeholders, reported in Section 4 above. The Leadership Team then

used the following criteria for selecting the final priorities and goals.

- Level of rankings across all processes for a specific population group
- Existing or potential of working on the issue by the Title V Offices
- Ability to influence change in a measure with activities conducted or leveraged by the Title V Office in both agencies
- Leadership for the priority area is handled in another sector or state agency

The challenge with selecting priorities are that many of the issues rooted in problems related to social determinants of health like poverty, employment, education, health care access, and language or cultural differences. Balancing the expressed need with the scope and current uses of Title V resources presented the greatest challenge in deciding on final priority goals for action.

Direct Health Care Services
Needs:
Disparities or inequity in access to health services is apparent for all populations, and particularly for families of color, immigrants with resident children, and all persons living in rural and isolated areas, particularly for families with children with special health needs. In both urban and rural/frontier communities, there is a particular deficiency in available mental health and dental health services and providers. Services are needed that meet the traditional or transitional needs of those who are non-English speaking, non-white, have little or no health insurance, and/or living in rural and frontier areas of the state. Public funding or support, combined with untrained health and service providers are needed to begin reducing these disparities and inequities in access to medical, dental and mental health care access. The Oregon Primary Care Office reports on Oregon's Health Professional Shortage Areas (HPSA) show that Oregon has 102 primary care HPSAs, 76 dental care HPSAs, and 54 mental health HPSAs.

Oregon geography presents a significant barrier to obtaining care where the mean travel time is 23.7 minutes in rural Oregon, with several areas taking up to an hour or more to the nearest hospital facility. The distance to services is especially difficult for reaching specialty care needed by CYSHN and their families. Specialty care is concentrated in urban areas, predominantly in Portland. There is little or no specialty care services in the rural or frontier counties, where the existing providers are not adequately trained to provide care for CYSHN.

Oregon geography presents a significant barrier to obtaining care where the mean travel time is 23.7 minutes in rural Oregon, with several areas taking up to an hour or more to the nearest hospital facility. The distance to services is especially difficult for reaching specialty care needed by CYSHN and their families. Specialty care is concentrated in urban areas, predominantly in Portland. There are few, if any, specialty care services located in the rural or frontier counties, where the existing providers report they are not prepared to provide care for complex CYSHN.

With mental health wellness a major concern across the MCH populations, not only is access at issue but also availability of age-appropriate, family-centered, culturally appropriate services. The community mental health system meets only 46 percent of the need, and many providers are not trained in screening of young children for social-emotional and behavioral problems or for maternal depression disorders. Improvement in availability of preventive screening, referral sources, care coordination and management, and treatment, particularly by pediatric providers, is needed for preventable and manageable mental health conditions. Input by stakeholders included a need for mental health services that are integrated or co-located with primary care service delivery, that meet the language and cultural norms of all persons needing care. Mental health consultation for pediatric primary care providers and for families of children and youth with special health needs would help to bridge primary care or community services who have inadequate access to mental health specialists. Access is also a problem for new mothers may lose coverage on the Oregon Health Plan two months postpartum, and therefore lose the ability to continue treatment for maternal depression, if needed. Flexibility in the policies regarding coverage of the

mother as it relates to the early development of the child is needed to prevent the negative effects of maternal depression and other behavioral and mental health disorders.

Dental health care is a concern, especially for pregnant women and very young children. Prenatal and pediatric health care providers are not trained or confident in screening pregnant women for oral health diseases, and dentists are reluctant to serve under/uninsured women and children. Stakeholders reported a need to assure fluoride varnish is applied in well-child visits and to provide dental insurance or care up to six months postpartum for pregnant women, where the Oregon Health Plan currently covers dental care for pregnant women through two months postpartum. Oregon citizens have a long history of advocating, as well as opposing fluoridation of community water systems and this issue continues to be a high priority for optimal prevention of early childhood cavities.

Opportunities:
The needs identified for direct services are preventive or are early interventions that prevent associated conditions across the individual's lifetime. Opportunities to build capacity in direct services was identified by the Title V Group and will help guide additional capacity assessment and planning for each of the priority areas.

Enabling Services
Needs:
Community-based supports and coordination of services are needed to assure MCH populations are able to reach available services. Parents need access to information, training, skill-building and support systems that help them nurture and support the developmental and emotional needs of the young child in all families. Resources and mentors for parents, including fathers, are needed to assure children have the attachment and bonding needed for optimal social emotional health. Families of CYSHN in particular have complex social, emotional, medical, and financial needs. Family support and resources and help these families address these needs and better navigate through the systems of care. Cultural competence in all aspects of service delivery is especially important as Oregon demographics shift to more first and second generation immigrant families.

Adequate resources in the community, at schools, and at worksites are needed to bridge gaps and inequities for linking families to information and services they need to establish healthy and safe families. Outreach can be more effective by using natural supports, such as faith organizations, apartment buildings, and community organizations, to connect to needed physical, dental, mental, and specialized services. Statewide home visiting services and supports need to improve policy and program coordination at the state level to better support outreach and linkages for clients to appropriate resources and programs.

Opportunities:
The needs identified for enabling services are focused on reducing the gaps in services inherent in Oregon's rural/frontier geography and the need to include extended family members not traditionally part of the federal MCH population definitions. Opportunities for enabling services identified by the Title V Group will provide foundations for continuing assessment and planning around each of the priority health issues.

Population-Based Services
Needs:
Stakeholders raised concerns about the limited protective community practices and preventive health care services available to reduce behaviors and conditions that increase risk and safety among families. These include community practices about healthy choices for food and exercise, and preventive services that support healthy mental and physical health conditions. Messages and information about mental health wellness and services could be improved to reduce stigma among those needing mental health services. Increased understanding and awareness by community organizations, schools, health, and service providers is needed to improve

community-based investments that support prevention of intimate partner or domestic violence, early brain development and parent-child interaction, as well as healthy food choices and exercise.

Preventive screening of children and adolescents should occur where they are, such as child care, Head Start, and schools to identify CYSHN and link them to appropriate resources and services.

Communities need to be plan and build environments that support families, pregnant women, fathers, and children and youth with special health needs. Communities can be built so that healthy choices are the easy choices for children, youth, and their families. Social marketing and health education that is cultural appropriate could increase healthy choices limiting access to sweetened beverages for children under five years old, increasing affordable and available fresh fruits and vegetables, and reducing TV or computer screen time for all children.

Public education and awareness is needed to increase preventive physical, dental, and mental wellness screening of children and adolescents, perhaps by increasing screening in locations where these populations are located during the day, like schools and child care centers.

Community-based health promotion would increase the understanding about local practices that can prevent preventable communicable and chronic diseases, including cavities and obesity and overweight conditions. Adolescent-friendly settings are needed to provide affordable and comprehensive physical and mental health services, as well as support and promotes positive youth development. Culturally appropriate education and discussion about sexual health behaviors is needed to increase acceptance among diverse populations and settings.

Opportunities:
Population-based services cover the promotion of preventive practices and activities that can be implemented by communities appropriate to the diversity of their own populations. Stakeholders suggested opportunities that provide healthy choices and health education in neighborhoods, worksites, and educational and faith institutions. Programs currently in some communities could be expanded statewide to reach more populations or adapted to reach those communities experiencing disparities. Population-based opportunities identified by the Title V Group will guide additional capacity assessment and planning.

Infrastructure and Systems Building
Needs:
Oregon's infrastructure and systems have gaps, strengths, and emerging activities that address the concerns and needs across all MCH populations, though disparities continue to exist within the systems of health care and community-base prevention services. Additional capacity assessment is needed to determine where and how to address the gaps and barriers in Oregon's system of services for the MCH populations. From the stakeholder input, the overriding need in statewide or community infrastructures and systems was the lack of cultural and linguistic appropriate services that are linked or coordinated with the established services and providers, especially for mental health and preventive physical and dental health services. A critical need is for integrated and more effective care coordination throughout the health services and preventive care delivery system. An effective system that is responsive to the community it serves is needed to increase access to appropriate and comprehensive mental health services, dental health services, and preventive physical and developmental services. State policies and professional practice standards could mandate that interpretive and language services are always available in service delivery in all parts of the state. Resources in funding and in expertise are needed assist communities in building safe neighborhoods with readily available walkways to schools, physical activities, and healthy choices in food.

Training and continuing education for the health and community service providers is needed to increase knowledge about delivery and care coordination for MCH populations, particularly for

young children and children and youth with special health needs. Service and health providers need culturally appropriate training in preventive screening for women and pregnant women for depression, oral health, tobacco/alcohol and drug use, intimate partner violence, and appropriate weight. The statewide infrastructure could invest resources in to support community efforts to build systems that provide linkages and coordination among services and referral sources and delivery of health and health related services.

The expanded use of technology, such as electronic health records, will effectively coordinate and provide more efficient health services wherever people access those services. Technological options are underused in Oregon, particularly in rural and frontier areas where connectivity continues to be a problem. Access to specialists and health consultants through on-line video discussions would greatly enhance the availability of services appropriate to the need of individuals and families. Training and increased connectivity is needed to increase the use of technology in rural and frontier areas as well as with populations experiencing disparities caused either by geographic or ethnic isolation.

Opportunities:
The MCH system of services and supports for families has many opportunities both through existing efforts and resources to build infrastructure and through local initiatives or demonstrations that can be expanded to other communities. Stakeholders suggested opportunities for improved infrastructure are found in maximizing technology conveniences, conducting assessments and surveillance to better define problems and interventions, and investing resources in systems or methodologies most efficient to addressing the issues. Opportunities for building infrastructure in several areas were identified by the Title V Group and this list guide additional capacity assessment and planning.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	48	36	60	51	61
Denominator	48	36	60	51	61
Data Source				Oregon Public Health Lab	Oregon Public Health Lab
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Source: Newborn Screening, Public Health Lab.
2009 data based on the total number of referred positives as reported on Form 6.

Notes - 2008
Source: Newborn Screening, Public Health Lab.

Notes - 2007
Source: Newborn Screening

a. Last Year's Accomplishments
Oregon participated in the Northwest Regional Newborn Screening Program. The newborn screening (NBS) panel included all 29 of the conditions recommended by the American College of Medical Genetics.

Systems remained in place to assure that all infants with a positive test result receive diagnostic testing and to ensure a health care provider accepts responsibility for treatment and/or monitoring. The primary care physicians of children with metabolic conditions requiring treatment or monitoring are offered long-term assistance and follow-up through the OHSU/CDRC metabolic clinic, the only comprehensive metabolic center in the state. Block Grant funds partially support this clinic. The primary care providers of infants with hemoglobinopathies and endocrinopathies detected by NBS are offered assistance through the OHSU Doernbecher Children's Hospital's specialty programs.

The CaCoon Public Nurse Home Visiting Program continued to provide community-based care coordination for qualified children with conditions detected by NBS.

Oregon law requires public and private third party payers to cover medical food and formula for individuals born with errors in metabolism needing medical food for optimal growth and development. The Oregon WIC program and OHSU/CDRC Metabolic clinic continued to provide medical formula for eligible children under age five.

Information for parents and healthcare providers was maintained on the Northwest Regional Newborn Screening Program website at http://www.oregon.gov/DHS/ph/nbs/

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State law mandates that all newborns receive metabolic screening			X	
2. Contractual partnerships between Oregon State Lab and CDRC/OHSU	X			X
3. Practitioner manuals updated and distributed throughout the state; online resources available			X	
4. Collaboration between CDRC Metabolic clinic and WIC to assure medical formula provided for infants/children under the age of five with metabolic disorders of metabolism (e.g.:PKU)		X		X
5. Assure follow-up and treatment through CaCoon, Community Connections Network and CDRC Genetics and Metabolic Clinics	X	X		
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Systems continued to be in place to assure all infants with positive NBS results received diagnostic testing and a health care provider accepts responsibility for treatment/monitoring. To assure access to accurate, timely information about NBS, information for parents and healthcare providers was maintained on the Northwest Regional Newborn Screening Program website.

A secure web-based tool developed by OSPHL is available to hospitals and physicians to obtain newborn screening test results for patients.

To improve tracking of outcomes and services provided to children with conditions detected by NBS, and to assure eligibility of these children for the CaCoon program "Positive Newborn Blood Screen" was added to the CaCoon Eligibility List. In addition, the CDRC metabolic clinic began entering information on individuals followed through the clinic into a long-term follow-up database. Informed consent is required prior to data entry.

The Oregon NBS program continues to participate in a multi-state HRSA-funded grant aimed at improving the experiences of parents whose children receive positive NBS results.

Telemedicine visits for management/monitoring children with metabolic conditions detected by newborn screening was discontinued this year due to the high cost of coordinating the visits compared to the small number of patients seen.

The Oregon WIC program and CDRC Metabolic clinic provided medical formula for eligible infants/children under age five.

c. Plan for the Coming Year
The current newborn screening panel including the 29 conditions recommended by the American College of Medical Genetics will continue throughout the next year.

The newborn screening program will investigate whether to add Severe Combined Immuno Deficiency to the screening panel as recommended in January 2010 by the Secretary's Advisory Committee on Heritable Conditions in Newborns and Children.
The primary care physicians of all children with metabolic conditions requiring treatment or monitoring will continue to be offered assistance and follow-up through the OHSU/ CDRC Metabolic clinic. The primary care providers of infants with hemoglobinopathies and endocrinopathies detected by newborn screening will continue to be offered assistance and follow-up through the OHSU Doernbecher Children's Hospital's pediatric hematology and endocrinology programs.

As children with metabolic conditions detected by tandem mass spectrometry are seen in the OHSU/CDRC Metabolic Clinic, new information on the children will continue to be added into the OHSU/CDRC Metabolic Clinic long-term follow up database.

The CaCoon Public Nurse Home Visiting Program will continue to offer community-based care coordination and follow-up for children with conditions detected by newborn screening. The CaCoon Public Nurse Home Visiting Program will continue to enter data for children with conditions detected by newborn screening that are served by these programs into the Oregon Community Health Integrated Data System (ORCHIDS).

The Oregon WIC program and CDRC Metabolic clinic will continue to provide medical formula for eligible infants/children under the age of five who have inborn errors of metabolism.

The CDRC metabolic nutritionist will continue to monitor third party reimbursement for metabolic foods and formula, and to promote a national policy of third party reimbursement for medical foods.

NBS information for the public, parents, and health care providers will be maintained on the OSPHL NBS program website at http://www.oregon.gov/DHS/ph/phl/.

The OSPHL will continue to offer WebRad, a secured web-based tool giving hospitals and physicians the ability to obtain newborn screening test results for their patients.

OSPHL, OFH, and CDRC staff members will continue participation in the Western States Genetic Services Collaborative, and other regional and national work groups and committees. OSPHL and CDRC staff will also continue to participate in multiple regional and national newborn screening-related committees and workgroups, including those on emergency preparedness and long-term newborn screening follow up.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**47650**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	47650	100.0	10	2	2	100.0
Congenital Hypothyroidism (Classical)	47650	100.0	452	28	28	100.0
Galactosemia (Classical)	47650	100.0	13	0	0	
Sickle Cell Disease		0.0				
Biotinidase Deficiency	47650	100.0	10	2	2	100.0
Cystic Fibrosis	47650	100.0	260	9	9	100.0
Isovaleric Acidemia	47650	100.0	14	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	47650	100.0	2	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	47650	100.0	78	5	5	100.0
Long-Chain L-3-Hydroxy Acyl-CoA	47650	100.0	3	1	1	100.0

Dehydrogenase Deficiency						
Hyperphenylalanemia	47650	100.0	1	1	1	100.0
ASA (Arginiosuccinate lyase deficiency)	47650	100.0	2	2	2	100.0
MMA (Methylmalonic acidemia)	47650	100.0	13	2	2	100.0
SCAD (Short-chain acyl CoA deydrogense deficiency	47650	100.0	5	1	1	100.0
CPT1a (Carnitine palmitoyl transferase)	47650	100.0	1	1	1	100.0
MCAD (Medium-chain acyl CoA dehydrogense deficiency)	47650	100.0	6	4	4	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59	55	55	56	57
Annual Indicator	54.6	54.6	55.5	55.5	55.5
Numerator	62990	62990			
Denominator	115367	115367			
Data Source				NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57	57	57	57	57

Notes - 2009
Similar to national estimates (57.5 percent), slightly more than half of Oregon families of CSHCN (55.5 percent) indicate they are partners in decision making at all levels and are satisfied with services they receive.

Notes - 2008
Similar to national estimates (57.5 percent), slightly more than half of Oregon families of CSHCN (55.5 percent) indicate they are partners in decision making at all levels and are satisfied with services they receive.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
OCCYSHN Family staff worked with local teams and Community Consultants to ensure families were active in decision-making and the teams practiced family-centered care. Three teams lost Family Liaisons (FL) due to work commitments or relocation. The Lincoln County team added a FL. The Coos Bay Team only met occasionally and Klamath Falls has unfortunately discontinued meetings. However, OCCYSHN conducted community engagement activities in Klamath Falls which targeted family needs in the community. Family staff was reduced by .50 at close of Integrated Services grant. However, FLs were sustained with OCCYSHN funds. FL Handbook and a FL recruitment packet was completed and disseminated to CCN Teams and other key partners.

Over 70 families were part of the Family Involvement Network with about 25 actively engaged in work.

Family Professional Partnerships (FPP) remained high priority for OCCYSHN as well as with family organizations, coalitions, OFH, LEND, WSGSC, CDRC and OHSU. OCCYHSN strengthened partnerships with Oregon Lifespan Respite, American Association of Public Health Dentistry, and Hands and Voices. Through these partnerships OCCSYHN has increased opportunities for family involvement and family input at the community and state level.

OCCYSHN staff and Oregon Family Voices collaborated to provide family input on policy and legislative issues, including hearing aid bill, expanded coverage for children, and others.

Family staff helped coordinate the training of LEND Family Discipline Trainee. OCCYSHN family staff also served as Family Faculty for seminars and training around family needs.

Change of management for Family to Family Health Education Information Center reduced OCCYSHN's level of engagement with project activities. Family staff partnered with WA Family to Family Health Education Information Center in training for family navigators.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Families are on OCCYSHN staff and active partners on internal committees, activities and leadership				X
2. Families are involved in community based activities	X	X		X
3. OCCYSHN staff partner with state agencies, organizations and family groups to provide family perspectives, identify issues and share information				X
4. OCCYSHN partners with other areas of CDRC to promote family centered care and family leadership				X
5. OCCYSHN disseminates information and provides education to assist families in decision making		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
OCCYSHN continues to support Family Liaisons on 10 CCN teams. Family staff was reduced to .6 FTE due to budget changes. OCCYSHN pursued additional funding to support family professional partnerships and medical home activities including writing in a position for a Family Consultant in the ASD grant proposal.

OCCYSHN continues collaborative activities with OHSU/CDRC partners including LEND and clinics, to assure family participation in decision-making, family-centered and culturally competent services. Cultural competency in community and state level activities as well as recruitment of Family Liaisons remains a strong priority. OCCYSHN developed a collaborative relationship with Juntos Podemos, a Latino family support organization, to improve outreach to Latino CYSHN and their families and better address their support needs.

OCCYSHN continues to support family leadership development and education through partnerships with Family Voices and other family-driven organizations. Education about CYSHN and family-centered care remains a high priority. This year OCCYSHN pursued alternative methods to train and connect families in the Family Involvement Network (FIN). Other activities included collaboration with key partners to educate early childhood providers about CYSHN. OCCYSHN's FIN Manager also assisted with WA Family to Family leadership training.

OCCYSHN continues to collaborate with OFH around family partnership and inclusion in program and policy decisions.

c. Plan for the Coming Year
Over this next year, OCCYSHN will continue to explore ways to expand family involvement in decision-making at the local level, including family participation in LICC's, family partnerships with CaCoon and county public health departments, and managed care or provider groups. OCCYSHN will continue partnership and collaborative efforts with family groups and family leaders, including Juntos Podemos, Family to Family Health Information and Education Centers, NW Down Syndrome Association, Family Voices, newly forming Oregon Parent to Parent, and others. Partnership activities with LEND, CDRC and OHSU Clinics, and others to assure quality care, patient and family-centeredness, and medical home will also be continued over the next year. OCCYSHN will work collaboratively with OIDD and its Community Partners Council, CCA and Office of Family Health to convene Youth Health Forum and assure family and youth involvement in planning and presentation at the Forum.

OCCYSHN will attempt to increase funding, training and support for Family and Youth Involvement at the community and state levels and within OHSU. OCCYSHN will also continue to pursue family and youth leadership development opportunities such as participation on grants, as trainers/presenters/faculty, participation on quality improvement efforts, and involvement on community based teams. Furthermore, OCCYSHN plans to pursue efforts that increase youth and family participation with pediatric and primary care practices, health plans and public health.

Family Liaisons, families involved in the Family Involvement Network and others will be recruited to assist OCCYSHN with dissemination activities, in particular the dissemination of the results of the CYSHN needs assessment. Information and education materials including the needs assessment results will be made available on the OCCYSHN website. Updates to the OCCYSHN website to include improved information and resource links for CYSHN and their families are estimated to be completed early this next year.

OCCYSHN plans to strengthen collaboration with families and family groups to identify and educate state legislature on issues and impacts of proposed legislation on CYSHN and their

families.

With the potential of supplemental grant funds from HRSA, OCCYSHN will ensure that families across the state have access to services and information related to State Autism Plan Recommendations.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	53	53	53	48
Annual Indicator	52.3	52.3	47.4	47.4	47.4
Numerator	60337	60337			
Denominator	115367	115367			
Data Source				NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	53	55	55	55

Notes - 2009
Nearly half of Oregon CSHCN (47.4 percent) received coordinated, ongoing comprehensive care within a medical home. This is nearly identical to the percentage of CSHCN nationally who were estimated to have received care in a medical home (47.1 percent).

Notes - 2008
Nearly half of Oregon CSHCN (47.4 percent) received coordinated, ongoing comprehensive care within a medical home. This is nearly identical to the percentage of CSHCN nationally who were estimated to have received care in a medical home (47.1 percent).

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
OCCYSHN's CCN program provided a medical home for CYSHN and their families. CCN teams across the state met monthly to provide multidisciplinary team care coordination/problem solving for CYSHN. Family members continued to work on CCN teams as Family Liaisons to provide support and advocacy for families seen by CCN.

Last year OCCYSHN took an active role in educating and training key stakeholders on the

promotion of medical home. For example, CCN consultants worked with local hospitals to offer Grand Rounds topics on medical home. In addition, OCCYSHN's CaCoon nurse consultants trained local PHNs on Medical Home. Updates were also added to the OCCYSHN website related to current research and best practices on Medical Home as well as key resource links.

To improve access and quality of care for CYSHN and their families, OCCYSHN connected with key entities such as OFH, OPCA, ONA, NWECI, OPS, FV and Oregon Health Access Campaign. OCCYSHN also worked with key partners to prepare information related to Primary Care/Medical Home, insurance and hearing aids for children for the legislative session beginning Jan 2009.

To better reflect the promotion of medical home within the CaCoon program, OCCYSHN conducted an assessment of the ORCHIDS data. The data demonstrated that 96% of children seen by CaCoon nurses were assessed for access to a medical home. 90% of children had access to a medical home for at least part of the year.

OCCYSHN partnered with LEND to provide training and education on Autism Spectrum Disorders and appropriate care/Medical Home for children with ASDs. Staff participated in several LEND activities and committees including the Family Mentor Project, Curriculum Committee and Training Coordinator Council.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Resources on chronic condition management through the OCCYSHN Web page			X	X
2. Education and training programs focus on comprehensive care of chronic conditions			X	X
3. Promote effective communication between providers, consumers and programs		X		X
4. Public Health Nurses (CaCoon) and Community Connections Network (CCN) ensure families of CYSHN receive care coordination		X		
5. Participate in collaborative efforts to increase recognition of medical home and initiate policy and practice change				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN continues to advocate for Medical Home through state policy work, partnerships and advocacy with managed care groups, DMAP, and provider organizations. Information on Medical Home best practices is being disseminated to legislators, agency leaders, and others around the state. Within OHSU, OCCYSHN worked with the School of Nursing, School of Medicine and clinics to encourage Medical Home including Family Professional Partnerships.

The development and dissemination of information about medical home and care coordination is a high priority. Specific activities include partnering with the OFH to develop a data/resource guide, disseminating information on Medical Home and best practices at a statewide primary care conference, and disseminating information about CCN and CaCoon to FQHCs. To reach a broader audience OCCYSHN is redesigning of its Medical Home website.

The CaCoon program supported several efforts to promote medical home and care coordination. Such activities include partnering with local ENCCs in their managed care groups to ensure coordinated care, working to increase TCM reimbursement to LHDs for care coordination, and examining ORCHIDS system to evaluate reporting of medical home assessments and capacity for reporting care coordination. A survey of CaCoon PHNs was also conducted to assess knowledge and understanding related to H1N1 and access to appropriate care.

OCCYSHN submitted CaCoon program to AMCHP for review and was designated as a Promising Practice.

c. Plan for the Coming Year

OCCYSHN will continue to advocate for a Medical home model through state policy work, advocacy and partnerships with state-wide organizations and local managed care groups. OCCYSHN plans to disseminate medical home research, best practices, state activities, and local and state opportunities for involvement through established dissemination routes.

CCNs will continue to provide care coordination for CYSHN and their families through integrated community-based care. OCCYSHN will continue to provide training and consultations to CCN teams and community based partners to increase comprehensive, ongoing, coordinated care within a Medical Home. The Family Involvement Network will continue include principles of medical home as part of the core training for families. OCCYSHN will also continue to support community engagement efforts.

The CaCoon program will continue quality improvement through improved contract language with LHDs and annual chart reviews that include review for care coordination language in progress notes and on-going technical assistance for standards of care. Technical assistance will be provided through a variety of activities including webinars, telephone and email contact and county site visits. In addition, the CaCoon program will provide training to CaCoon nurses regarding access to antivirals relative to H1N1 per results of Nurse Survey in FY2009.

OCCYSHN will partner with OFH and DHS to provide oversight for the implementation expanded TCM reimbursement. OCCYSHN will support the implementation of expanded TCM at the local level by providing technical assistance and evaluation. Examination of opportunities to maximize CaCoon dollars and the new TCM reimbursement options will occur over the next year.

OCCYSHN will continue to network with FQHC providers to provide information about CaCoon and CCN programs, to educate about the needs of CYSHN, and to explore community-based partnerships.

OCCYSHN will examine the Early Childhood Service Intensity Instrument and the CASII as potential tools to improve collaboration and care coordination for CYSHN and their families. OCCYHSN plans to pilot the instruments within CaCoon and CCN prior to implementing statewide.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Performance Objective	58	56	56	62	62
Annual Indicator	55.7	55.7	61.5	61.5	61.5
Numerator	64259	64259			
Denominator	115367	115367			
Data Source				NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Almost two-thirds of families of CSHCN in Oregon indicated they have adequate public and/or private insurance to pay for needed services (61.5 percent). In comparison, the percentage of families indicating adequate public or private insurance was nearly identical (62.0 percent).

Notes - 2008
Almost two-thirds of families of CSHCN in Oregon indicated they have adequate public and/or private insurance to pay for needed services (61.5 percent). In comparison, the percentage of families indicating adequate public or private insurance was nearly identical (62.0 percent).

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
OCCYSHN participated in discussions with families, providers, policy makers and partners, including the Human Services Coalition of Oregon and the Expanded Access Coalition to identify, track and provide information on health care access and finance issues impacting CYSHN.

The OCCYSHN director and family staff participated in multi-state technical assistance meeting with Catalyst Center and ABC for Health, on ensuring families' access to full benefits of health insurance and system of care services.

OCCYSHN collaborated with OHSU government relations, professionals, organizations, and families to successfully pass legislation for hearing aid coverage in state regulated insurance plans. Continued collaborations with DMAP have also strengthened CYSHN's access to appropriate genetic services. To support this work, OCCYSHN and DMAP reviewed 2007 data on the use of genetic testing services by OHP enrollees.

OCCYSHN provided consultation and support to CaCoon PHNs, CCN teams, families and others about financial hardship and impacts of insurance and coverage decisions. OCCYSHN sponsored trainings for CaCoon, CCN teams, and other community partners included strategies to help families find and pay for needed services and supports. Through training and technical support, CaCoon PHNs were able to better assist CYSHN and families enrolled in the CaCoon program find/get needed insurance coverage and services.

OCCYSHN developed the CCN Toolbox, a web based resource housed on the OCCYSHN website, to assist community providers and families find needed services and financial supports.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate implementation of gift fund to address families' out-of-pocket expenses		X		
2. Health care finance (HCF) education and advocacy activities				X
3. Strengthen partnerships with families, providers, insurers, and legislators to address the concerns of HCF				X
4. Provide financial support to tertiary clinics at CDRC and community based programs		X		X
5. Partner with DMAP to address genetics services coverage on OHP				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN continues to strengthen linkages with managed care plans and DMAP in order to track coverage limitations and identify successful strategies for accessing services for CYSHN. OCCYSHN's ongoing collaboration with DMAP and the Oregon Health Services Commission assists CYSHN gain access to appropriate genetic services. Through this collaboration OCCYSHN gained access to data on the use of genetic testing by OHP recipients. However, analysis of 2008 data is currently delayed due to problems associated with the new DMAP data system.

OCCYSHN provided training and consultation to CCN teams and CaCoon PHNs regarding access to insurance and community financial resources for CYSHN and their families. Trainings were posted on the OCCYSHN website. Updates were also made to the website and CCN Toolbox to include resources and strategies for maximizing health benefits, finding financial resources, and limiting financial hardship on families. In addition, OCCYSHN family staff continue to identify information and supports for families and provide consultation to Family Liaisons about financial resources and health insurance coverage.

OCCYSHN continues to facilitate CDRC medical consultations to community-based programs and local health care providers, especially in rural areas.

The tracking of health reform efforts and initiatives within the state and nationally remains a priority. OCCYSHN disseminates information related to health reform and the impact for CYSHN to key stakeholders.

c. Plan for the Coming Year

OCCYSHN will continue to track, prioritize, inform and disseminate health reform efforts, legislative initiatives, emerging policy concepts, and related activities as they relate to the impact on CYSHN/families within the state and nationally. In addition, information about activities and policy development around Medical Home in Oregon will also be disseminated.

OCCYSHN will continue to update its website and CCN Toolbox with resources and strategies for maximizing health benefits, finding financial resources, and limiting financial hardship on families.

Over the next year, OCCYSHN plans to identify methods to track financial impacts related to inadequate coverage, denials, or other matters related to insurance and necessary supports for CYSHN. In addition, OCCYSHN will continue to develop stronger linkages with managed care plans and DMAP in order to track coverage limitations and identify successful strategies for accessing services for CYSHN, including those related to medical home. With technical assistance from the Catalyst Center, OCCYSHN will focus on strengthening its relationship with DMAP to increase assessment/evaluation of health care finance issues. Through collaborations with OFH and other key partners, OCCYSHN also plans to identify quality measures related to adequate coverage and financing for CYSHN.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	74	74	90	90
Annual Indicator	73.9	73.9	88.3	88.3	88.3
Numerator	85256	85256			
Denominator	115367	115367			
Data Source				NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	92	92	92	92

Notes - 2009
Nearly 90 percent of families of CSHCN in Oregon (88.3 percent) and nationally (89.1 percent) reported that community-based systems are organized for ease of use.

Notes - 2008
Nearly 90 percent of families of CSHCN in Oregon (88.3 percent) and nationally (89.1 percent) reported that community-based systems are organized for ease of use.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
OCCYSHN sustained the CaCoon program in all 36 counties and the Community Connections Network Teams in 14 counties. Program criteria for both CaCoon and CCN were expanded to include family involvement, health disparities, cultural competency, and Youth Transition for all program efforts via contracts with communities. OCCYHSN also reviewed quality improvement procedures with its CaCoon program. Performance standards were implemented to assure continued excellence in program performance.

OCCYSHN continued partnership with key state leaders on the Early Childhood Council to improve health status of young children.

Through the efforts of the Oregon ABCD Early Childhood Screening Initiative, OCCYSHN worked in collaboration with OFH and EI/ECSE to support development and dissemination of an early childhood universal referral form. OCCYSHN staff also assisted in the coordination and evaluation of the Oregon ABCD demonstration project. Evaluation of the demonstration project was completed by OCCYSHN evaluation staff with consultation from CAHMI to assess the impact of screening and referral practices before and after the implementation of standardized screening tools.

OCCYSHN analyzed internal data to identify needs/gaps in services for CYSHN. This data allowed OCCYSHN to explore options to improve and sustain home visiting programs for CYSHN.

OCCYSHN partnered with Family-to-Family Health Information and Education Center/Family Voices. FIN staff worked with Families and Communities Together (FACT), and local support brokerages to host a multi-county resource fair for families and professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OCCYSHN and family participation in state level program and policy planning groups to assure CYSHN priorities and cultural needs are addressed				X
2. OCCYSHN/CaCoon provides care coordination, including hospital/clinic discharge to community	X	X	X	X
3. CCN and local Family Liaisons work to identify local resources, fill service gaps, develop strategies to meet needs of CYSHN in local communities	X	X		X
4. Identify/enhance resources about services and systems of care for families and providers (Disability Compass, OCCYSHN, Bulletins, Newborn Handbook)			X	X
5. WSGSC/OCCYSHN explore and pilot alternative service delivery methods including telemedicine		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
OCCYSHN continues to explore opportunities to support and strengthen systems of care for CYSHN within rural communities including opportunities to engage rural-based health care collaboratives. A statewide learning collaborative regarding behavioral health and development

with a focus on children and youth with Autism Spectrum Disorder is currently being developed. OCCYSHN continues to support the development and expansion of Medical Home statewide. In addition to the expansion of Medical Home, OCCYSHN is partnering with DHS/OFH/DMAP on ABCD III efforts surrounding care coordination within pediatric primary care practices.

In response to budget reductions, OCCYSHN is exploring options to improve and sustain CCN and CaCoon care coordination programs. Several evaluation and assessment activities are currently underway. OCCYSHN is evaluating methods for enhancing operation of local CCN teams; increasing family participation; and improving activities at the community-level. In addition, ORCHIDS data is being assessed to identify current needs/gaps in services for CYSHN seen by CaCoon nurses.

OCCYHSN continues to conduct training and annual site visits for the CaCoon program to assure quality improvement in program practices. The CCN toolbox is being expanded to include more community resources. The use of web technology has allowed OCCYSHN to provide training and resources to CCN Teams and CaCoon nurses statewide while reducing travel and related costs.

c. Plan for the Coming Year

OCCYSHN will design and implement an assessment of the overall impact of improved community-based systems of care through monitoring and measuring for key indicators per technical assistance by Champions Inc. (initiated FY2010). An annual report of each community-based program, CaCoon and CCN, will be produced and disseminated and utilized for continuous program improvement.

OCCYSHN will continue its trainings to assure high standards of practice through its CCN and CaCoon programs and the Family Involvement Network. This year CCN consultants will support "cross-trainings" among CCN sites as method for disseminating best practices across all sites in Oregon and thus strengthening the system of care beyond site catchment boundaries. OCCYSHN will also continue to expand the CCN Toolbox to include additional community resources.

OCCYHSN will continue to explore options to improve, sustain and spread care coordination programs for CYSHN. Such efforts will include disseminating models for community-based care coordination such as CCN and identifying existing care coordination efforts happening within communities. OCCYHSN also plans to increase coordination of community-based systems of care through ongoing linkages with other OHSU and CDRC community outreach efforts including the expansion of specialty care in rural areas across the state. OCCYSHN will work with CDRC leadership to increase family involvement within specialty clinics.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	10	6	6	45	45
Annual Indicator	5.8	5.8	43.7	43.7	43.7
Numerator	6691	6691			
Denominator	115367	115367			

Data Source				NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	48	48	48	48	48

Notes - 2009
Over 40 percent (43.7) of CSHCN youth in Oregon between the ages of 12 and 17 were estimated to have received services needed for transition to adulthood. National estimates for this performance measure indicate a similar percentage (41.2 percent).

Notes - 2008
Over 40 percent (43.7) of CSHCN youth in Oregon between the ages of 12 and 17 were estimated to have received services needed for transition to adulthood. National estimates for this performance measure indicate a similar percentage (41.2 percent).

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
OCCYSHN partnered with ODE, Shriners Hospital staff, CDRC clinics, Addictions and Mental Health Services, OrPTI, Family Voices, and others to address issues related to YT. OCCYSHN strengthened connections with state groups, including Oregon Association of Vocational Special Needs Personnel, UCP, to support transition issues.

The OCCYSHN Youth Advisory Group (YAG) met quarterly. Members shared goals and supported each other to achieve these goals. Meetings included discussion and skill building re: Job Development, Working with Providers, and Personal Health and Wellness. OCCYSHN staff and YAG members also presented sessions on YT for LEND students.

Following the ending of supplemental funds from the Strengthening Oregon's Communities grant, the YAG and ELNW worked toward integration for sustained YT activity. OCCYSHN continued as a participant of the ELNW consortium and helped to add health care transition to the ELNW curriculum. YAG and ELNW youth participated in "Dream It Do It" camp both as participants and leaders. A YAG and ELNW member presented "Become a Director of Your Own Life" at 2009 Administration on Developmental Disabilities Youth Information, Training and Resource Center's Technical Assistance Institute. A few YAG members also continued to participate as ELNW members; one YAG member became an employee of CDRC. In addition, the YAG Coordinator received a scholarship to AMCHP and participated in the annual meeting.

OCCYSHN sustained emphasis on Youth Transition in trainings and education offered to CaCoon PHNs, CCN teams and Family Liaisons. A survey of PHNs assessing transition services for

adolescents seen by the CaCoon program was also conducted.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate information and strategies for successful youth transition		X	X	
2. Support Youth Advisory Group, CaCoon nurses and Community Connections Network (CCN) teams in addressing transition needs throughout the life cycle				X
3. Partner with communities, families, schools and providers in addressing Adolescent Transition (AT) health care concerns				X
4. Promote AT issues and Youth Involvement within program, agency and policy arenas				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN, OIDD, LEND, and other OHSU entities continue to work toward sustaining youth involvement and YT emphases, including seeking funding and opportunities for shared activities and training. OCCYSHN continues to explore opportunities to engage youth within its own program including capturing youth and family perspectives on health care and YT during the planning and implementation of the 5 year Needs Assessment. OCCYSHN also provides in-kind support through staff participation in ELNW and Dream It Do It activities. In addition, OCCYSHN is partnering with OFH's Adolescent Health Section and OIDD's Center on Community Accessibility to plan a Youth Health Forum in early 2011.

OCCYHSN completed a HRSA grant proposal focused on improving transition to the adult healthcare system for youth and young adults with ASD and their families. The CCN and CaCoon programs continue to connect with School Based Health Centers and Educational Service Districts to address YT issues and exchange best practice information. Youth pages are being added to the OCCYSHN website and YT resources are being added to the CCN Toolbox.

OCCYSHN participated in efforts to expand TCM payments up to age 21 for care coordination by local PHNs, resulting in increased age limit to commence July 2010. CaCoon nurse consultants are currently focusing on providing technical assistance to PHNs around transition. The survey results of YT services provided by CaCoon PHNs were analyzed and presented to CareOregon.

c. Plan for the Coming Year

OCCYSHN will explore Youth Involvement opportunities in conjunction with other CDRC efforts, including clinical programs, UCEDD activities, OHSU Adolescent Health, Shriner's Hospital and partnership efforts with INCIGHT and ELNW and others. OCCYSHN also plans to evaluate its involvement in COIT (CDRC/ODE Interagency Team) as a possibility to enhance collaborative efforts on YT.

OCCYSHN will convene a Youth Health Forum with key stakeholders and decision-makers in February 2011. With assistance from partners, OCCYSHN will follow-up on action plans or action

steps developed at the Youth Health Forum.

If funded, the Autism grant will allow opportunity to increase efforts related to YT and increase joint work with the state's Oregon Commission on Autism Spectrum Disorder (OCASD) Transition Workgroup to assure inclusion on health and related services in transition planning. OCCYSHN will contribute to efforts of OCASD related to YT and encourage health care providers and public health professionals to participate in state and local councils on YT.

OCCYSHN will continue efforts to inform and educate health care providers, including family practitioners, internists, and adult specialty providers, about YT issues specific to youth and young adults with special needs. CCN consultants will also assist and support multidisciplinary CCN Teams in addressing issues facing youth and their families related YT. Family staff plan to add a section to Family Liaison Handbook related to YT, including planning and resources for youth and their families. OCCYSHN will also continue CaCoon training and support for local PHN's related to YT and support expanded age limits for TCM funding. Lastly, OCCYSHN will develop Youth Needs Assessment Survey and identify effective methods to disseminate the survey to youth across Oregon.

Plans to update the OCCYSHN website are already underway. Information and education materials related to YT and youth with special needs will be available on the updated website in Fall 2010. These materials will also be disseminated to youth and family groups, health care providers, and educators through direct mail, email and other dissemination pathways.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79	80	75	79	79
Annual Indicator	72	78.4	72.4	72.4	72.4
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	77	77	78	78	80

Notes - 2009
2008 and 2009 data not available. 2007 data carried forward.

Interpretation integrated into year 2008 data.

Notes - 2008
Source: National Immunization Survey (http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis).
This data not available for 2008 and 2009, therefore 2007 numbers carried over.

The correct percentages for 2004 and 2005 are 78.9 and 72.9 respectively.

The percent of Oregon two year olds receiving all recommended immunizations has remained stagnant over the past four years. While Oregon is not expected to meet the Healthy People 2010 national series objective of 80%, Oregon is on track to meet the 90% Healthy People 2010 goals for Polio, Measles, Mumps and Rubella, Haemophilus influenza, and Hepatitis B. Furthermore, rates among individual antigens are generally strong and most meet HP 2010 goals.

Confidence intervals (around ± 7) continue to be too large to assess any real change over the years. This is true for most states, so comparisons over the years are irrelevant.

Notes - 2007
Target for 2007 should be changed to 79.0%

a. Last Year's Accomplishments
In 2009, a minimum of 741,965 doses of vaccine valued at $29,743,056 were shipped to public and private providers statewide.

Several thousand health care and school professionals use Oregon's two Immunization Information Systems (IIS) -- ALERT the statewide registry and IRIS the public-sector electronic record. Both have a direct impact on Oregon's ability to improve immunization practices and avoid costly duplicate doses.

ALERT sent monthly recall reports to over 350 Oregon clinics for two-year-old children who were overdue for shots. Oregon's Immunization Program used ALERT data to create comprehensive reports about immunization practices for private and public clinics, and immunization quality improvement measures.

Recall postcards were sent to children statewide who were not up-to-date on immunizations from ALERT and IRIS data systems.

The Oregon Immunization Program provided Immunization Practice Assessments (AFIX - Assessment, Feedback, Incentives, and eXchange) to every Medicaid-contracting health plan with a report detailing the immunization coverage rates of their two year-olds. A project between DMAP and Medicaid began to implement quality improvement strategies focused on increasing immunization rates for two year olds. Interventions are focused on assessment of immunization rates by plan and recalls for past-due members.

Oregon Partnership to Immunize Children (OPIC) and Immunization Program co-hosted two Roundtable meetings in Fall 2009 that focused on parent vaccine hesitancy and vaccine management. These meetings were well attended and received high evaluation marks.

Developed immunization rates for counties that are population-based and client-based to support the program efforts in DMAP and WIC who assist in improving immunization series completion. Rates can be found at http://www.oregon.gov/DHS/ph/imm/Research/index.shtml

The OPIC Health Disparities Workgroup led development of statewide partnerships and

measures to monitor and respond to changes in access to immunizations during the economic downturn.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School immunization laws in place to assure all children in children's facilities are up-to-date annually			X	X
2. Vaccines for Children and the 317 Programs provide vaccines for eligible populations		X		
3. Outreach about immunization disseminated through training, consultation, and health education				X
4. Immunization information systems (IIS) track immunization status and recall individuals				X
5. AFIX assessment for public and private providers monitors clinic rates and identifies gaps and needs for providers		X		X
6. WIC screens and refers any participants aged 3-24 months for immunizations		X		X
7. WIC and Immunization programs collaborate and coordinate services at the state and local levels				X
8. FamilyNet client data system links immunization and WIC client data				X
9. County-specific immunization rates produced annually and shared with local partners to improve targeting of population-based strategies			X	X
10.				

b. Current Activities

Immunization Program is:

Producing and disseminating 2008 population-based immunization rates by ethnicity, race, county of residence, WIC enrollment, Babies First enrollment, and DMAP enrollment for use by DHS, local health departments and community partners.

Continuing AFIX activities to improve immunization coverage rates across the state with healthcare providers and health systems continue.

Coordinating with tribal clinic partners to provide technical support and to assure that all American Indian and Alaskan Native children have access to recommended immunizations.

Continuing annual funding through performance-based contracts to thirty-four LHDs supports their direct and population-based services to communities.

Assessing the impact of pandemic H1N1 influenza on timely completion of regularly scheduled childhood immunizations.

Implement new Immunization Information System that will combine ALERT and IRIS registries.

c. Plan for the Coming Year

Provider education will continue to promote the Vaccines for Children (VFC) program to eligible populations, the need for reasonable administration fees, and appropriate client billing.

VFC will offer technical assistance and consultation to support partnerships between public and private immunization providers.

Produce and share population-based immunization rates by county and partner program status for 2010 with local partners.

Launch a statewide social marketing campaign to reach vaccine-hesitant parents.

Collaborate with Public Health nurses, through the Babies First and CaCoon home visitation program, to identify best practices to improve immunizations for their populations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	16	15.5	15	15	17
Annual Indicator	15.8	17.7	16.6	17.5	15.3
Numerator	1151	1303	1228	1314	1150
Denominator	72821	73444	73997	75054	75370
Data Source				Oregon Center for Health Statistics	Oregon Center for Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	14	13.5	13.5

Notes - 2009
Numerator: Oregon Center for Health Statistics
Denominator: Oregon Population Research Center

The birth rate for teenagers (15-17) went back up between 2005 (15.8) and 2006 (17.7), but then dipped in 2007 (16.6), went back up in 2008 (17.5) and then down again in 2009 (15.3). The three year average from 2007 to 2009 shows a reduction to 16.4 per 1,000 teens, from the high of 17.7 in the single year 2006. Oregon rate is only about one-third of the HP 2010 objective to reduce pregnancies among females aged 15-17 to no more than 46 per 1,000 females aged 15-17 years.

Notes - 2008

Numerator: Oregon Center for Health Statistics
Denominator: Population Research Center
The birth rate for teenagers (15-17) trended upwards between 2004 (15.6) to 2006 (17.7). The three year average from 2006 to 2008 shows a slight reduction to 17.3 per 1,000 teens, from the high of 17.7 in the single year 2006.

Notes - 2007
Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments
The Adolescent Sexual Health (ASH) Program Coordinator played an active role in the Teen Pregnancy Prevention-Sexual Health Partnership (TPP-SHP). TPP-SHP is a public-private partnership - membership includes: Oregon Department of Education, Oregon Commission for Children and Families, Department of Human Services Youth Services Program, Oregon Public Health Division (Family Planning Services, HIV/STD Prevention, Adolescent Health), Planned Parenthood Affiliates, Cascade AIDS Project, local health departments, the Attorney General's Sexual Assault Task Force, and the Oregon Teen Pregnancy Task Force (OTPTF). TPP-SHP meets monthly to assess and evaluate statewide teen pregnancy prevention work, including promotion and support of the Oregon Youth Sexual Health Plan.

In April 2009, The Adolescent Sexuality Conference was held in Seaside Oregon. Approximately 250 youth service providers and youth attended sessions on pregnancy prevention, STI prevention, healthy relationship promotion and ways to outreach to youth.

In April 2009, The Rational Enquirer was distributed at the Adolescent Sexuality Conference and via direct mail to 3,000 Oregonians. The Rational Enquirer, a youth-focused magazine addressing sexual health, is an annual publication of the Oregon Teen Pregnancy Task Force in collaboration with Office of Family Health. Distribution includes adolescent pregnancy prevention agencies, youth service providers and youth themselves. In summer and fall 2009, the ASH Program Coordinator held seven focus groups (2 with youth service providers and 5 with youth) to gather feedback on The Rational Enquirer. The feedback will be used to make improvements to the 2010 edition, specifically making it more "youth-friendly."

The Office of Family Health provided written and oral testimony in favor of Oregon House Bill 2509, requiring comprehensive, age-appropriate, medically accurate sexuality education for Oregon public school students grades K -- 12.The bill passed and is now Oregon Revised Statute 336.455.

The ASH Program Coordinator served on the My Future My Choice Advisory Board. My Future My Choice (MFMC) is a comprehensive sexuality education curriculum developed in Oregon to replace the abstinence-only program previously offered in the state. MFMC is managed by TANF, in the Children, Adults and Families Division of Dept. of Human Services. The curriculum is being piloted in school districts throughout Oregon. The Office of Family Health assisted with the design of the process evaluation and development and implementation of the pilot-site assessment protocol.

In July 2009, Oregon was awarded a private foundation grant to institutionalize sexuality education throughout the state. The Adolescent Sexual Health Program Coordinator was the lead writer of the grant request and is actively involved in grant activities. Through the grant, six school districts are receiving intensive technical assistance and training to improve sexuality education.

In August 2009, Title V funds were used to support development of model classroom education sessions. The state program is collaborating with the Deschutes County Health Department to develop two classroom sessions - one on birth control methods and the other on sexually transmitted infections. These sessions are designed for county-based family planning providers or health educators to deliver in high-school health classes as a means for strengthening partnerships between the school and the health department and increasing youth awareness of sexual health services available in their communities.

In August 2009, The ASH Program Coordinator attended a conference sponsored by Advocates for Youth on strengthening state-based teen pregnancy prevention programs with Oregon Teen Pregnancy Task Force Co-Chairs.

Two Adolescent Health staff served on the Oregon School Based Health Care Network's EC Brown Grant Advisory Committee. EC Brown Grant funds are provided to School-Based Health Centers to improve partnership activities in support of sexual health of youth.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with other agencies to implement teen pregnancy prevention strategies				X
2. Provide technical assistance to county health departments and other organizations working toward teen pregnancy prevention goals				X
3. Implement, support and coordinate actions to meet objectives of the Oregon Youth Sexual Health Plan			X	
4. Teen pregnancy prevention media campaign raises awareness of adolescents, parents and other adults.				X
5. . Collaborations with schools and other programs, such as Coordinated School Health				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OFH's Adolescent Health and Women's Health Managers began participation in a one-year AMCHP Action Learning Collaborative on Preconception Health for Young Adults with Disabilities. Lessons learned from the cooperative will be used to support preconception health of younger groups.

The Adolescent Sexual Health (ASH) Program Coordinator became the co-chair of the Teen Pregnancy Prevention-Sexual Health Partnership in January 2010.

In March 2010, the ASH Program coordinator hosted a webinar for county health department family planning providers and other interested parties on the birth control and STI prevention classroom sessions developed in Deschutes County.

In March 2010, the Adolescent Health Manager presented on using survey data on sexual

minority youth to support LGBTQ (lesbian, gay, bi-, transgender, queer) programs in the Adolescent Reproductive Health Disparities Summit.

The AHS funded and staff support for the April 2010 Adolescent Sexuality Conference, attended by about 275 youth and youth service providers.

The Adolescent Health Section is applying for the DHHS-OPHS-Office Of Adolescent Health Tier 1 Teenage Pregnancy Prevention: Replication of Evidence-based Programs cooperative agreement to implement the Safer Sex Intervention in up to five sites throughout the state. The proposal will provide motivational interviewing and safe sex education for female adolescents at risk for unintended pregnancies or sexually transmitted infections.

c. Plan for the Coming Year

The Adolescent Sexual Health program will continue to provide support and technical assistance in implementation of the Oregon Youth Sexual Health Plan.

Through The Teen Pregnancy Prevention Sexual Health Partnership, the Adolescent Health Section will prepare a report on the progress in implementation of the Oregon Youth Sexual Health Plan.

The Adolescent Sexuality Conference will be held in April 2011 at Seaside, Oregon, and supported by the Adolescent Health Section.

The Adolescent Health Section will continue to closely monitor teen pregnancy and birth rates. Teen pregnancy and birth rate increased from 2005 to 2006, and decreased in 2007. Preliminary data shows that the pregnancy rate decreased slightly from 2007 -- 2008.

The Adolescent Health Section Manager will serve on the Association of Maternal and Child Health Programs Reproductive Health Disparities Advisory Board.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	52	52	44
Annual Indicator	50.0	42.0	42.7	42.7	42.7
Numerator	650	546	1261	1261	1261
Denominator	1301	1301	2953	2953	2953
Data Source				Oregon Smile Survey	Oregon Smile Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	44	50	52	55	55

Notes - 2009
Data for this measure is available only every five years through the Oregon Smile Survey. 2007 data carried forward. Next SMILE survey year is 2012.

Notes - 2008
Data for this measure is available only every five years through the Oregon Smile Survey. 2007 data are carried forward for 2008.

Notes - 2007
Source for 2002-06: Oregon Smile Survey, 2002.
Numbers for 2004-2006 should be 50.8% and not 42%, however unable to enter 2006 value in TVIS. First Smile survey conducted in 2002, so is carried forward subsequently to 2006.

Source for 2007-2011: Oregon Smile Survey, 2007.

More than half (42%) of third graders children in Oregon do not get protective sealants on at least one permanent molar tooth. HP 2012 objective is to increase the proportion of children who have received dental sealants on their molar teeth to 50 percent. Compared to the baseline (23%) between 1988-94 of children aged 8 years having received sealants on their molars, Oregon is making progress but much disparity still exist due to shortage of dental providers in rural areas, and various parts of Oregon.

Several interventions have been conducted in collaboration with the Oregon Oral Health Program and community partners to increase preventive screenings to children, so Oregon expects to see an increased in children having dental sealants with 2012 survey.

a. Last Year's Accomplishments

The Oral Health Program (OHP) in the Office of Family Healthincreased the number of schools participating in the school-based dental sealant program from forty three in school year 2007-08 to sixty two in the 2008-09 school year. Over 11,000 children were served and close to 25,000 dental sealants were placed in the 2008-09 school year.

The Oral Health Program leveraged state general funds that support the school-based dental sealant program to expand the program. The OHP contracted with a few regionally based dental hygienists to coordinate the program locally and recruit more volunteers to provide the services to more schools.

The Oral Health Program conducted a feasibility study on incorporating a retention check component into the school-based dental sealant program.

The Oral Health Program piloted a project to test the feasibility of collecting insurance information on the parental permission forms and subsequently billing the Oregon Health Plan or third party payer. A final report was submitted in November 2009 and identified specific barriers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. . Community-based and school-linked partnerships are supported through statewide technical assistance from the Oral Health Program				X
2. . Smile Survey provides assessment data to monitor status of sealants			X	
3. Dental sealant promotion campaign to raise awareness of the benefits of sealants			X	
4. Statewide sealant program partnering with schools			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program is operating the dental sealant program in over one hundred forty eight schools. Estimates of over 58,000 sealants will be provided to children aged six through eight.

The Oral Health Program is collaborating with partners to address access to care and reimbursement for services issues that were identified through the feasibility study and pilot project, both conducted in 2009.

Oral Health Program is applying for the CDC grant to build infrastructure, including activities to focus on gaps in the current dental sealant program such as retention checks, billing, data collection needs and cost benefit analysis.

c. Plan for the Coming Year

Schools participating in the dental sealant program in the previous year will continue to participate. Over 200 schools are targeted for the 2010-11. Since overall oral health status is dependent on numerous factors it is impossible to project the impact that the school-based dental sealant program will have on dental sealant rates when the next Smile Survey is conducted in 2012. However, some impact is expected as our program targets first and second graders and we anticipate being able to provide more sealants before decay sets in. Previously, our program targeted second and third graders. Preliminary data from CDC's SEALS data analysis program indicates that we are able to seal a higher rate of teeth and have far less children unable to receive sealants due to un-erupted teeth than was initially predicted.

The Oral Health Program will be coordinating with state and local partners to identify opportunities through the school-based dental sealant program screening process to assure treatment for refer children identified with urgent treatment needs. Additionally, we will be also working to utilize existing systems to get all children with treatment needs (non-urgent) identified through the screening process into care.

The Child Health Collaborative, a local-state public health partnership, identified Child oral health as a priority issue. The Oral Health Program will be working closely with other MCH section colleagues and partners from local county health departments to create an action plan to provide broad oral health prevention services to children between the ages of 1and 8.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.4	3.2	2.8	2.8	3
Annual Indicator	3.0	3.3	1.4	1.4	1.4
Numerator	21	23	10	10	10
Denominator	699202	702864	724681	724681	724681
Data Source				CDC-WISQARS	CDC-WISQARS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.3	1.3	1.3	1.3	1.3

Notes - 2009
2009 not available, 2007 data carried forward.

Notes - 2008
2008 not available, 2007 data carried forward.

Notes - 2007
Numerator from CDC Web-based Injury Statistics Query and Reporting System (http://www.cdc.gov/injury/wisqars/index.html).
Denominator from Oregon Population Report (http://www.pdx.edu/prc/annual-oregon-population-report).

Rate remains around 3 between 2004-06, then decreased in 2007 (1.4). The difference could be due to a data issue; this is mostly true with injury data among certain age groups because data might have been submitted to WISQAR before close out for the year. For future reporting, our plan is to align with how Oregon's injury program reports in order to have complete data. Increased motor vehicle injury prevention in Oregon, such as increased seat belt use, could have contributed to the decrease.
.

a. Last Year's Accomplishments

Safe Kids Oregon assisted two chapters (Columbia Gorge and Central Oregon) in capacity building to move into coalition status. In additional, one county in Washington joined the Columbia Gorge coalition, making it the first bi-state coalition.

Safe Kids Oregon and Safe Kids Washington worked together to reorganize the Safe Kids Blue Mountain coalition in Walla Walla, with a new lead agency, St. Mary's Hospital. Since the hospital is a Level 2 Trauma hospital, the coalition agreed to include the

eastern Oregon chapters in their trauma region, thus becoming the second bi-state coalition in Oregon and Washington, and moving two more Oregon chapters into coalition status.

The Child Injury Prevention Program (CIPP)/Safe Kids Oregon partnered with the Child Safety Seat Resource Center to identify counties in need of nationally certified Child Passenger Safety (CPS) Technicians. Monthly Technician courses are now scheduled throughout Oregon. Additionally, the programs partnered to identify "senior" CPS Technicians to provide a senior leadership role at local child safety seat clinics, and increased the numbers from 54 to 61. Part of this process was the development of a Technician Evaluation Tool that is now being implemented by CPS instructors statewide.

The CIPP/Safe Kids Oregon program developed a reporting tool, and provided training on the tool statewide for child passenger safety. The tool, combined with scanned forms, provided data to complete a statewide child passenger safety report on numbers of families served at local car seat clinics; the numbers of child safety seats that were distributed statewide; and the correct installation data for improvement processes.

The CIPP/Safe Kids Oregon program provided a statewide training opportunity in October in conjunction with the Transportation Safety Conference. The program hosted an ATV Injury Reduction Forum in the Portland area. Funds for scholarships were procured and provided to help Safe Kids coalition coordinators attend the statewide conference.

The CIPP/Safe Kids Oregon program produced its first annual Safe Kids injury report to establish baseline indicators in each coalition throughout the state.

Safe Kids Oregon also secured a single-source contract for tax-deductible contributions. Due to this opportunity, Safe Kids Oregon also engaged in a fundraising project to send a runner to the Marine Corps Marathon as a Team Safe Kids Runner and raised $1700.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Child Injury Prevention Program and Safe Kids Oregon, supported by Title V, promotes motor vehicle safety for children. Safe Kids Oregon is the state office of the national Safe Kids.			X	X
2. Car seat safety promotion occurs through state and local media, local safety events				X
3. Safe Kids Oregon provides support and technical assistance in the development of local coalitions		X	X	
4. Public Health Nurse home visiting programs provide anticipatory guidance and health education to parents about car seats				X
5. Training for certified safety seat technicians occurs throughout the state			X	
6. Safety seat inspections by local certified technicians assures correct use of seats				X
7. Statewide needs assessments for child safety seats provides information for programs				X

8.				
9.				
10.				

b. Current Activities
Safe Kids Oregon (SKO) will work with Lane County to either achieve coalition status or be only a child passenger safety project. There are 8 coalitions, 4 chapters, and the state office (supported by Title V), geographically representing over 85% of the state's children ages 0-14. Efforts will be undertaken in 2010 to assist Klamath County into chapter status, delayed in 2009.

The CIPP/SKO program is implementing an Oregon Department of Transportation grant to provide a follow-up evaluation report to a 2007 study that identified where need was greatest for child safety seats statewide. This evaluation will determine whether low-income families received the services needed and a cost benefit analysis of 3 years of funding and training to reach these families.

CIPP/SKO is providing injury prevention safety information to the public by utilizing a website blog. The same site is providing access to documents and reports needed by local coordinators, including local data on child passenger safety efforts.

The SKO Board is finalizing a 3-year strategic plan, which includes fund raising plan to support infrastructure of both the state office and local coalitions. In 2010, at least one fund raising project will be implemented.

The CIPP/SKO program is collaborating with Safe Kids Washington and Safe Kids Utah to offer a regional training Sept. 28-29, 2010.
CIPP/SKO staff will work with all chapters and coalitions to create new 2-year Needs Assessment plans.

c. Plan for the Coming Year
The CIPP/SKO program will partner with the Child Health Collaborative leaders in the Office of Family Health to build unintentional injury prevention projects at the county health department level.

CIPP/SKO has a second Oregon Department of Transportation grant that is providing additional technical support to Safe Kids chapters and coalitions statewide in sustaining local child passenger safety efforts during a recessed economy. The grant is providing support in particular to Columbia County's CPS efforts, continuing to provide training with coalitions and partners through the state on registering clinics and activities on the national website, and continuing to develop and recruit Senior Checkers throughout the state in order to increase registered events.

The CIPP/Safe Kids Oregon program will do onsite evaluations with the 3 remaining chapters to determine whether they will achieve coalition status.

The CIPP/Safe Kids Oregon program will raise a minimum of $20,000 in order to retain a Health Educator at .40FTE.

The CIPP/Safe Kids Oregon Health Educator will focus on training DHS staff in Child and Family Division on Child Passenger Safety. A key focus will be to develop CPS Techs in staff at regional offices that build CPS programs for child protective service workers and foster families. These programs will include maintaining training among staff and providing appropriate seats and equipment in circulation.

The CIPP/Safe Kids Oregon program will host a day at the capitol, and educate legislators on emerging child injury issues. The Safe Kids Public Policy and Education Committee will host a community forum in the fall, linking to the same emerging issue(s).

Safe Kids Oregon will collaborate with Safe Kids Washington and Utah again for a regional conference and will host a Childhood Window Fall Prevention Forum in November.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		55	58	60	63
Annual Indicator	53	56.4	62.1	62.1	63
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	63	64	64	65	65

Notes - 2009
Source: CDC - Breast Feeding Report Card, www.CDC.gov/breastfeeding/data.

Notes - 2008
The most recent data for this measure indicates that 62.1% of Oregon women breastfed their infants at 6 months in 2005, the highest percentage of any state and a slight increase over the 2004 percent (59.6). Both numbers are substantially higher than the Healthy People 2010 objective of 50%. Updated with correct data from National Immunization Survey, new data from NIS not avilable until late 2009.

Updated data (2008 Report)

2004 = 59.6%
2005 = 62.1%
2006 = 62.1%

Note on 2006 Note: the data in this note is no longer up to date.

Notes - 2007
Source: National Immunization Data, CDC. Table 2, Geographic-specific Breastfeeding Rates among Children. Correct trends are:
2004= 59.6%
2005= 62.1%
2006= 62.1%

a. Last Year's Accomplishments
Oregon continues to have among the highest breastfeeding initiation rates in the country. The CDC Breastfeeding Report Card demonstrates that Oregon exceeds the national average for all indicators. (http://www.cdc.gov/breastfeeding/data/report_card2.htm)

The cross-office "Breastfeeding Think Tank" in the Title V agency, Office of Family Health (OFH), continued innovative activities such as promoting the Breastfeeding Mother Friendly Employer project and creating a resource on the internet (http://www.oregon.gov/DHS/ph/bf/working.shtml); providing breast-feeding information in the Newborn Handbook; tracking breastfeeding experiences through the statewide SafeNet hotline; and participating in World Breastfeeding Week. There has been continued dialogue with the Department of Medical Assistance Programs (DMAP -- Oregon's Medicaid Agency) to assess lactation services and care offered through their contractor programs.

The law relating to expression of breast milk at work (House Bill 2372, ORS 653.077) has been in effect since January 1, 2008. This law is the strongest in the country guaranteeing workplace accommodation for breastfeeding mothers. The law applies to pumping breast milk, addresses time and space needs and provides a remedy for non-compliance. It covers 70% of the Oregon workforce and applies to full and part time workers. Partnership with the Bureau of Labor and Industries continues in order to implement the law. Support is provided to mothers and employers needing help to implement the law. WIC has developed material to inform all women about the law.

OFH continued to promote Senate Bill 744 (1999 Executive Order), which affirms a women's right to breastfeed in public. Business cards explaining the law continue to be available in English and Spanish.

WIC continued to promote and support a breastfeeding pump project. Pumps are provided to WIC participants through funding provided by the USDA and WIC provider training includes a breastfeeding training module. Additionally, Oregon WIC program completed the breastfeeding peer counselor research project.
TANF (Temporary Assistance for Needy Families) and WIC partnership continues to support working breastfeeding mothers, the only collaboration of its kind in the nation. TANF continued to implemented their breastfeeding policy that assures mothers are encouraged to breastfeed and are referred for services especially WIC.
Every new TANF employee continues be trained on the importance of breastfeeding and the policy. WIC developed a brochure specifically for TANF clients, which has been translated into six languages, and includes information about the law requiring rest periods for expression of milk.

OFH Nutrition Consultant staff are involved with The Breastfeeding Coalition of Oregon and participate in the regional and state meetings.
WIC implemented new breastfeeding policies to support exclusive and continued breastfeeding

among clients.

Public health nurses provide anticipatory guidance, health education, assessment and support for parents after birth to assure and support optimal health through breastfeeding for clients enrolled in Maternity Case Management and Babies First.

OFH is continuing efforts to improve data quality from breastfeeding surveillance by monitoring NIS data, PRAMS and PRAMS-2 data, and WIC data to determine breastfeeding initiation, duration, and exclusivity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breastfeeding surveillance includes state level data from PRAMS and PRAMS-2				X
2. Resources and technical assistance provided to women and employers through the Oregon Breastfeeding Mother Friendly Employer project to assure breastfeeding support in the workplace			X	
3. Governor's Executive Order in 1999 requires all state agencies have location for breastfeeding				X
4. Breastfeeding education and resources provided through the Newborn Handbook which is distributed through community partners to all pregnant women and new mothers				X
5. WIC, Perinatal, and home visiting programs provide education, support & referrals to all pregnant women about benefits, legal protections and available resources for breastfeeding	X	X	X	
6. Coordinate with & support Breastfeeding Coalition of Oregon			X	X
7. Collaborate with partners to support population-based planning and policy efforts to promote, protect & support breastfeeding			X	X
8. Collaboration and technical assistance provided in the implementation of Rest periods for expression of milk law (House Bill 2372; ORS 653.077)				X
9. TANF/WIC collaboration supporting working mothers		X	X	X
10.				

b. Current Activities

The MCH Nutrition Consultant will continue promotion and technical assistance of worksite support for the breast milk expression and return to work law (ORS 653.077) in partnership with the Bureau of Labor and Industries. Provide support to Breastfeeding Coalition in promoting HRSA's "The Business Case for Breastfeeding" model for improving worksite awareness and support for breastfeeding. Promote the Oregon Breastfeeding Mother Friendly Employer program, and through new CDC grant funding for worksite wellness, additional promotion and technical assistance is available for these efforts.
Continue dialogue with DMAP about coverage for lactation care and services through Oregon Health Plan programs.

Continue implementation and technical assistance for the TANF project that began in 2008.

Continue with breastfeeding promotion, support and protection through programs within the Office

of Family Health. The Breastfeeding Think Tank is beginning a new effort to address hospital breastfeeding practices in collaboration with outside partners.

Continue support and collaboration with the Breastfeeding Coalition of Oregon.

Breastfeeding projects in WIC will continue implementation and evaluation.

Continue breastfeeding surveillance activities.

c. Plan for the Coming Year

The Breastfeeding "Think Tank" of the Office of Family health will continue work on improving breastfeeding initiation and duration rates by implementing activities that raise awareness, provide breastfeeding education, and begin to address hospital breastfeeding practices in Oregon.

To continue to implement ORS 653.077, breastfeeding support pieces will continue to be distributed and promoted using HRSA's "Business Case for Breastfeeding" and "Oregon's Breastfeeding Friendly Employer Project.".

The WIC breastfeeding pump project, new peer counselor project, Fathers Supporting Breastfeeding, and advanced breastfeeding training will continue through 2011.

The worksite wellness grant funded project will implement breastfeeding support as part of wellness promotion.

MCH Nutrition Consultants will continue implementation of project recommendations of TANF population.

Continue to develop assessment, planning, and implementation of supporting breastfeeding in Division of Medical Assistance Programs (DMAP) perinatal regulations and emergency preparedness.

Oregon will participate in the World Breastfeeding Week by providing promotional materials to local health departments and WIC providers. An annual list of breastfeeding-friendly employers will be published during World Breastfeeding Week.

OFH will continue to partner with the Breastfeeding Coalition of Oregon, and Nursing Mother's Council.

Maternity Case Management and Babies First nurse home visiting programs will develop public health nurse practice guidelines for breastfeeding support at the population-based individual level of practice based on nursing standards.

Continue education for health professionals in breastfeeding management across the state (3 day Breastfeeding Basics course, 5-day Advanced Breastfeeding course and sponsorship of WIC staff to take the International Board of Lactation Consultants Exam will continue).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99.1	99.4	99.7	99.5	99.5
Annual Indicator	95.4	93.5	97.6	96.4	93.4
Numerator	44594	45516	48205	46455	44845
Denominator	46763	48684	49373	48190	47999
Data Source				EHDI and Oregon Center for Health Statistics	EHDI and Oregon Center for Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2009
2007 -2009 data: numerator: Early Hearing Detection and Intervention Program (EHDI)

For 2009, 93.4% of newborns in Oregon were screened for hearing before hospital discharge. This shows a decrease from 2008 (96.4%). The decrease is probably more of a data issue due to EHDI's tracking system (used up to 2009) that may have contributed to the numerator being under counted. Comparison across years is limited due to lack of information on how the numerator and denominator were defined in 2007 and earlier.

As of June 2010 EHDI is no longer using Hi-Track and has switched to using the Vital Statistics (Oregon Center for Health Statistics) tracking system which should result in more accurate numbers starting in 2010.

Notes - 2008
2004 data not seen in TVIS:
2004: denominator = 45,660; percentage = 94.9%

Notes - 2007
Source: Numerator: EHDI Reporting System; Demoninator: Oregon Center for Health Statistics.

a. Last Year's Accomplishments
The Office of Family Health (OFH), Early Hearing Detection and Intervention (EHDI) Program, in collaboration with partners from the Newborn Hearing Advisory
Committee and others, continued to provide technical assistance and support to hospital newborn screening programs, diagnostic centers and early intervention
facilities to promote early identification and intervention for children with hearing loss.

On-going technical assistance was provided to hospital newborn hearing screening programs, diagnostic audiology centers, and early intervention programs
regarding the reporting and follow-up protocols. In addition, the EHDI Program provided reports and feedback to these facilities assisting in ensuring infants receive
necessary follow-up services. Increased contact and coordination was promoted with infants' medical homes regarding their hearing status.

The EHDI staff hired a Parent Coordinator to establish a Parent-to-Parent mentoring program for parents who have newly identified children with hearing loss.
Regional Parent Guides were hired in September 2009 and began site visits and calls to families.

The EHDI Program created and disseminated informational brochures to parents about hearing screening and evaluation along with a "Parent Roadmap" to inform families of next steps to follow-up on their baby's hearing health. EHDI staff made a number of presentations to health care providers, including local public health departments, and early intervention staff about the EHDI program.

EHDI continued to generate follow up letters to families who had a child needing further testing and to collect information from non-hospital newborn hearing screening facilities.

The EHDI Program and Oregon Dept. of Education/Early Intervention Program have worked on improving protocols so that children at risk of hearing loss because of repeated failed screenings that are near 6 months of age are reported to Early Intervention and receive follow up. This revision has improved the number of children getting enrolled in early intervention before the 6 month goal.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement legislation requiring all hospitals with 200 or more births to conduct newborn hearing tests			X	X
2. Newborn data linking project includes diagnostic and early intervention data for children				X
3. Public education materials, such as the Newborn Handbook, provide information about hearing screening				X
4. Advocacy for policies and legislation to assure screening and referral access for all newborns				X
5. Technical assistance and consultation to screening and diagnostic centers and organizations				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The EHDI Data System improvements and efforts to link hearing testing data with other state systems such as the Birth Certificate Registry began in January 2010. Six hospitals representing 15% of the Oregon birthing population piloted the new system in an effort to capture more accurate data and link with other state systems.

EHDI is currently working on facilitating the second annual Pediatric Audiology Training for audiologists around the state to ensure children are appropriately being tested and that audiologists are knowledgeable about the evaluation procedures and new developments in hearing health.

EHDI is currently working on providing free hearing screening clinics for the uninsured and out of

hospital births. EHDI continues to loan equipment and oversee established free clinics in the three largest out of hospital birth counties but is looking to increase the number to have clinics around the state.

A statewide Pediatric Audiology Work group developed best practice standards for pediatric audiology testing. The EHDI Diagnostic Audiology protocol is being disseminated statewide to audiologist and it is being looked at as being incorporated into the state licensing standards.

EHDI is currently working on improving the loaner hearing aid bank accessibility and improved hearing aids so that they are available for uninsured children in need of hearing aids.

c. Plan for the Coming Year

EHDI will be partnering with Oregon Health and Science University (OHSU) to provide hearing evaluations for the uninsured and in rural communities without access to the necessary testing.

EHDI will be working with the Oregon Lions Hearing Foundation to pilot a hearing screening project for infants in remote locations.

The Office of Family Health and EHDI Program will continue to provide technical assistance and support to screening and non-screening birth facilities/providers, diagnostic centers and early intervention sites.

Education and training is provided through presentations to groups, which include providers, local public health staff and other identified community partners regarding the EHDI program protocols and information about hearing loss issues and resources.

EHDI follow-up staff will continue to contact families, medical home providers and local public health to assist families in navigating the system.

Progress will continue on activities related in the CDC and HRSA early hearing detection and intervention grants, related to follow-up system development, provider and parent education and family support. The CDC-EHDI grant has been renewed until 2011 and the HRSA UNHSI Grant has been renewed until 2011.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	12	12	12
Annual Indicator	12.0	12.6	12.2	12.2	11.6
Numerator	101616	119376	104057	104057	108672
Denominator	848001	947427	854842	854842	936824
Data Source				Natl. Survey Child.	CPS and OPRC

				Health	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10	9	9	8

Notes - 2009
Sources: Current Population Survey (2009 Annual Social and Economic Supplement) (CPS), available at: www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm; Oregon Annual Population Report (OPR), PSU.
Denominator: 2009 OPR where 0-18 population was derived based on total of 0-17 and estimate of 18 years old from the group 18-19 years of age. Numerator was derived with data from CPS and OPR. 2009 CPS data for children defined as <= 18 yrs old.

Any trends or differences between years should be interpreted with caution. Variability in the data sources could contribute to differences.

Notes - 2008
The correct percent of children without health insurance for the years 2004-2006 is 13%.

The percent of children 0-19 without health insurance declined from 13.0% to 12.6% from 2004 to 2006. The 2007 number (12.2%) is not directly comparable to the earlier numbers for two reasons: 1) it comes from the National Survey of Children's Health (NSCH) whereas the prior numbers come from the Oregon Population Survey; 2) the NSCH only covers children 0-17. Moreover, the NSCH was conducted in 2007 and does not account for the increase in unemployment (and likely concurrent increase in uninsurance) in 2008).

Notes - 2007
Source: National Survey of Children's Health, 2007.

a. Last Year's Accomplishments
House Bill 2116 was passed by the Oregon Legislature and signed into law by Governor Ted Kulongoski on August 4, 2009. The bill taxes hospitals and health insurers 1% of premium revenues. This expanded tax base will be matched with federal funds and will generate nearly $2 billion in revenue to insure an additional 80,000 uninsured Oregonian children by the end of the 2009-2011 biennium.

From June 15th, 2009 to December 15th, 2009, there was a net increase of 30,755 children (10.3%) enrolled in the Healthy Kids Program.

A "companion" reform bill, House Bill 2009, also passed by the Legislature includes multiple quality improvement and cost containment strategies such as: the creation of a statewide all-payers database, coordination of patient care through a medical home, standardizing and simplifying insurance paperwork, streamlining the health functions of the state through the creation of a citizen Oregon Health Policy Board and the Oregon Health Authority (OHA), in addition to other provisions.

In July 2009, the Department of Human Services launched the Healthy Kids website at

www.oregonhealthykids.gov. The site provides basic information about Healthy Kids, a link to the online application, and information for outreach partners and the general public.

Title V Programs in the Office of Family Health (OFH) and Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) worked with partners to strengthen benefits counseling for improved utilization of existing coverage and services for children with special healthcare needs, and enhanced outreach efforts to increase enrollment in public and private health insurance programs.

Office of Family Health staff worked with the Oregon Health Plan (OHP) and Division of Medical Assistance Programs (DMAP) to enhance outreach efforts, coordination, and simplification of the Medicaid application process, including simplifying initial and re-application materials, simplifying the procedures for obtaining application forms, and simplifying application completion by identifying nontraditional community-based application sites throughout the state.

Oregon School-Based Health Centers offered a variety of OHP enrollment programs based on local resources, including school-based outreach workers and health department employees that facilitate bilingual and expedient enrollment.

In September 2009, the Office of Family Health, in collaboration with the Office of Healthy Kids, was awarded a two-year Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach and Enrollment Grant for $1 million to focus on outreach and enrollment to eligible children of mixed status and unauthorized immigrant families.

In September 2009, Oregon was awarded a five-year, competitive HRSA grant to support health care coverage expansion efforts. This funding augments and supports efforts funded through House Bills 2009 and 2116 to expand health insurance coverage, improve quality and contain costs.

Adolescent Health engaged a graduate intern to perform research and draft a white paper policy proposal to extend health insurance coverage to older adolescents (age 18-25).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach and application assistance through local health department programs and home visiting programs		X	X	
2. Information and referral through toll-free number, SafeNet.		X	X	
3. Coordination and collaboration in MCH programs to simplify application.				X
4. Policy advocacy to sustain eligibility levels for Oregon Health Plan for children 0-18.				X
5. Collaboration to strengthen early childhood linkages with healthcare coverage initiatives.				X
6. Policy advocacy to maximize third party reimbursement for developmental screening, assessment, promotion and prevention services, and care coordination.				X
7. Oregon Title V MCH programs promote universal comprehensive insurance and healthcare for expectant parents,				X

children, adolescents, children and youth with special health needs, and their families				
8.				
9.				
10.				

b. Current Activities

CMS (Centers for Medicare and Medicaid Services) approved a waiver allowing expanded eligibility opportunities for children, including: 12 month continuous eligibility, elimination of asset test for most children, shortened uninsurance period of 2 months, expanded income limits for children from 185% to 200% FPL, and expanded Medicaid and CHIP eligibility to documented, immigrant children who have not resided in the country for 5 years. Oregon can provide premium assistance on a sliding scale for employer-sponsored insurance for children with family incomes from 200-300% of FPL.

Title V staff participate in monthly Healthy Kids Advisory Committee meetings, regular OHK team meetings, and cross-office Healthy Kids Evaluation Workgroup meetings. Staff identify collaborative and coordination opportunities with OHK.

Oregon School-Based Health Center sites were awarded funding to increase their outreach and enrollment activities to "hard to reach" populations.

The Oregon CHIPRA grant funds, administered through the OFH, were awarded through a competitive application process to 5 safety net provider organizations serving families in 12 counties in Oregon.

OHK marketing includes targeted mailings, population specific campaigns, transportation ads, billboards and radio spots.

Oregon House Bill 3664 created a new category of medical assistance for former foster care children between the ages of 18 to 21, requiring a State Plan Amendment by March 2010 for implementation.

c. Plan for the Coming Year

Offices across DHS and the Oregon Health Authority continue to develop strategies for marketing, outreach, and enrollment, as well as strategies to improve the state system. Efforts include: simplifying and streamlining the application, developing a "smart" online application and tutorial, more efficient eligibility determinations, improving the phone system information line, express lane eligibility, and ex parte renewals. Title V programs will continue cross-office collaborations to promote universal comprehensive insurance and healthcare for MCH populations through programs, policy development, collaborative leadership, and other activities across state and local programs.

Title V programs will continue to work with community partners and stakeholders to assure awareness of the Healthy Kids Program.

A new position within the Oregon Health Authority, the Medical Eligibility Transformation Manager, will be responsible for developing and implementing a strategy to transform the medical application and eligibility determination process for Healthy Kids, Oregon Health Plan, and other Oregon Health Authority-administered medical assistance programs.

Title V staff will continue to participate in monthly Healthy Kids Advisory Committee meetings,

regular OHK team meetings, and cross-office Healthy Kids
Evaluation Workgroup meetings.

The Office of Family Health will continue to administer the CHIPRA Outreach and Enrollment Grants to safety net providers, collaborate with the Office of Healthy
Kids and their Targeted Outreach Grantees, and seek opportunities to promote healthcare for all MCH populations in Oregon.

The Adolescent Health program will finalize and distribute a policy white paper on health insurance and the young adult population.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		31	33	33	32
Annual Indicator	31.2	31.8	32.1	32.3	32.8
Numerator	33437	14255	14613	15638	17290
Denominator	107169	44826	45525	48415	52713
Data Source				WIC	WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	32	31	30	30	30

Notes - 2009
Nearly a third of Oregon WIC clients between the ages of 2-5 years have a BMI above the 85th percentile. Compared with other states for the most recent data reported in TVIS (primarily 2008), Oregon's percentage is among the highest (worse) half of states

Notes - 2008
In 2010 Block Grant Report, preliminary data source from Pediatric Nutrition Surveillance System (PedNSS).

Notes - 2007
Source: Pediatric Nutrition Surveillance Survey.

a. Last Year's Accomplishments
As part of the FFY 2008-2009 Nutrition Education Plan, local agencies selected appropriate strategies and objectives from the Statewide Physical Activity and
Nutrition Plan appropriate for their populations and settings.

WIC implementation of the new food package, "Fresh Choices," changes on August 1, 2009. Changes to the food package support the Dietary Guidelines for
Americans and may impact the weight in children and adults by only providing lower fat milk, less cheese, more whole grain options and a cash benefit to purchase

fresh and frozen fruits and vegetables.

Local agencies distributed the Sesame Workshop Healthy Habits for Life kits to WIC families in Oregon. This kit includes resources to promote healthy eating and physical activity targeting children ages 2-5.

Local WIC staff were trained in participant-centered skills to use with WIC families. These skills help WIC families to identify their concerns and priorities around addressing and preventing overweight in children.

Staff have begun modifying the curriculum for "Breastfeeding Basics" and for the Breastfeeding Training Module to incorporate participant centered counseling skills and information from a California research project on Infant Cues to better support breastfeeding exclusivity and duration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess and monitor weight status for all WIC clients between 2-5 years of age; provide counseling to all parents on ways to promote healthy weight; clients at highest risk are referred to RDs, their medical provider and/or other resources in the comm	X	X		
2. Participate in and promote the following national and statewide public health campaigns: National Breastfeeding Week, Screen Time Awareness, Marketing Junk Foods to Kids Parent Awareness Campaign, Fruits and Veggies More Matters promotion			X	X
3. Improve the health outcomes of clients in the local agency service delivery areas through technical assistance and training for implementation of local Nutrition Education Plans			X	X
4. Continue promoting and supporting a participant-centered approach when working with WIC families to identify their concerns and priorities around addressing and preventing overweight in children.	X	X		
5. Collaborate with state nutrition programs and groups in identifying best practices for promoting healthy weight in families across Oregon.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FFY 2009-2010 Oregon WIC Program Nutrition Education Plan is designed to support and promote a comprehensive approach in the delivery of WIC services.
This structure involves a three-year strategy focusing on providing quality nutrition services, including nutrition assessment and education in preparation for the federally mandated implementation of the Value Enhanced Nutrition Assessment (VENA) project. The multi-year plan will continue to support the Oregon Statewide Nutrition and Physical Activity Plan, Breastfeeding Promotion, and MCH Title V National Performance Measures.

As part of the FFY 2009-2010 NE Plan, local agencies developed a plan to consistently promote the Oregon WIC Key Nutrition Messages related to the food package changes thereby supporting the foundation for health and nutrition of all WIC families.

Local agencies continued to distribute the Sesame Workshop Healthy Habits for Life kits to WIC families in Oregon.

For the first time, WIC began issuing vouchers to women and children for the purchase of fresh and frozen fruits and vegetables, "Fresh Choices."

WIC played an active role in the Breastfeeding Coalition of Oregon, in the other areas related to breastfeeding promotion and support.

WIC partnered with the Nutrition Council of Oregon to raise the awareness about junk food marketing to kids and provide resources and strategies for parents to help their kids make good food choices.

c. Plan for the Coming Year

The FFY 2010-2011 Oregon WIC Program Nutrition Education Plan is designed to support and promote a comprehensive approach in the delivery of WIC services. This structure involves a three-year strategy focusing on providing quality nutrition services and enhancing participant centered services. The multi-year plan will be reflecting of the Value Enhanced Nutrition Assessment (VENA) philosophy and continue to support Breastfeeding Promotion, the Nutrition Services Standards and MCH Title V National Performance Measures.

As part of the FFY 2010-2011 NE Plan, local agency staff will complete the new online Child Nutrition module as a way to increase their understanding of the factors influencing health outcomes.

WIC will continue to work as a partner with other USDA FSN programs through the Supplemental Nutritional Assistance Program (SNAP) collaboration to plan and implement a variety of physical activity and fruit and vegetable promotion.

Local agencies may continue to distribute the Sesame Workshop Healthy Habits for Life kits to WIC families in Oregon.

WIC plans to expand its Breastfeeding Peer Counseling Program to help promote breastfeeding exclusivity and duration.

WIC plans to distribute and develop resources related to Infant Feeding Cues to better support breastfeeding exclusivity and duration.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		11.6	12	10	10
Annual Indicator	12.1	10.7	10.3	11.1	11.1
Numerator	201	4939	4883	5225	5225

Denominator	1661	46146	47614	46882	46882
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10	10	9.5	9

Notes - 2009
After declines from 2005 to 2007, 2008 data shows a slight rise (11.1%) from 10.3% in 2007.

2009 not yet available, 2008 data carried forward.

Notes - 2008
From weighted PRAMS data, this measure is showing a decline in the percentage over the past 3 years from 12.1% (2005) to 10.7% (2006) to 10.4% (2007). PRAMS 2008 data is not yet available, so 2007 data is carried over.

Note: the PRAMS data for 2003-2005 in the 2006 Note for NPM #15 is no longer valid.

Notes - 2007
Source: PRAMS, 2006; weighted data.

a. Last Year's Accomplishments
Note: State Performance Measure 2 (2006-11 priorities) complements National Performance Measure 15, though NPM 15 focuses on cessation during the last 3 months of pregnancy. For purposes of research and comparisons of individual measures with other states or nationally, strategies and activities for both measures are replicated in the narratives for both measures in the Title V Information System.

Perinatal Health Program continued cessation screening and counseling in county services for family planning, prenatal care and Maternity Case Management (MCM), nurse home visiting for high risk infants, and WIC.

State Public Health Division implemented an Environmental Protection Agency (EPA) grant award for "Building Capacity to Address Environmental Exposures During Pregnancy." As a collaborative effort between the Office of Family Health (Title V) and the Environmental Health Section within the Public Health Division, the pilot project has been implemented in two county health departments.. The project is piloting the development and use of an environmental home assessment tool that contained a component addressing prenatal exposure to second and third-hand tobacco smoke.

Partnerships between DMAP (Division of Medical Assistance Programs), OFH, and local providers and agencies provided training, information, and education on the 2008 DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services;

OFH conducted continuous quality improvement to improve ORCHIDS/MDE reporting on tobacco use and cessation during pregnancy and ensure validity of reports for program evaluation and population surveillance.

PRAMS and PRAMS 2 collected and analyzed surveillance data on tobacco use in pregnant women as well as mothers with a 2-year-olds

The OFH state MCH Nurse Team provided a series of trainings to local county health nurses on 5A's for smoking cessation and Motivational interviewing during May and June 2009. There were a total of 8 offerings in locations statewide (Baker, 3 in Multnomah, Deschutes, Josephine, Lane and a final one here at the PSOB). Guest speakers were John Perkins and Karen Dluhosh from the Center for Health Training in Seattle. All counties with the exception of 4 attended. Total attendance was 135, comprised of PHNs, a few Family Support Workers from Healthy Start and State Nurse Consultant staff.

PH nurses around the state delivered tobacco education and 5-A's quitting support to pregnant women through home visiting maternity case management visits.

The Oregon Tobacco quitline implemented a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and technical assistance to local Maternity Case Management (MCM) providers on the Five A's Intervention and motivational interviewing for pregnant women.		X		X
2. Implement Demonstration Project in two counties to build capacity to address environmental exposures during pregnancy including second hand smoke.		X		X
3. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
4. Health education and social marketing about smoking during pregnancy through Family Planning and Babies First home visiting program services			X	
5. Screening and referral in Babies First, WIC and Family Planning client services		X		
6. PRAMS-2 (2-year old PRAMS follow up) data surveillance to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.				X
7. ORCHIDS (Oregon Child Health Information Data System) state and local level data reports on reported tobacco exposure during pregnancy and home visitor interventions to evaluate trends and level of intervention provided in MCH programs.				X
8.				
9.				
10.				

b. Current Activities

The 5As brief intervention for smoking cessation is now a required component of the MCM program and is included in the current 09-10 MCM Oregon Administrative Rules, OAR 410-130-0595.

Cessation screening and counseling is also continuing to be offered through county services for family planning, prenatal care, and nurse home visiting for high risk infants, and WIC.

Surveillance of perinatal tobacco use and cessation continues through PRAMS and PRAMS 2.

Monitoring and evaluation of county client data reports from ORCHIDS is being used to provide quality improvement for nurse home visiting services related to tobacco use in pregnancy, and to plan future programming by state and local partners.

The Oregon Tobacco quitline is continuing to provide a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

State Public Health Division continued implementation of the Environmental Protection Agency (EPA) grant award for "Building Capacity to Address Environmental Exposures During Pregnancy." The project is piloted the development and use of an environmental home assessment tool that contained a component addressing prenatal exposure to second and third-hand tobacco smoke. The project was completed and a final report submitted in April 2010

c. Plan for the Coming Year

Partnerships will continue with DMAP, local providers and agencies train and educate public health providers on perinatal tobacco issues, the use of the 5 A's protocol and the 2008 revised DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

Cessation screening and counseling in county services for family planning, prenatal care and Maternity case management nurse home visiting for high risk infants, and WIC will continue during 2011.

The Oregon Tobacco quitline will continue to provide a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

Evaluation of county client data reports from ORCHIDS will improve surveillance and monitoring on tobacco exposure during pregnancy and provider interventions.
The information will be used by the Perinatal Title V Program to plan for strategies in program services delivered by county health department partners.

Surveillance of perinatal tobacco use and cessation will continue through PRAMS and PRAMS 2.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective	6	6	7	7.5	9.5
Annual Indicator	7.4	8.1	8.4	11.3	11.3
Numerator	18	20	21	28	28
Denominator	244360	246476	248780	247556	247556
Data Source				Injury and Violence Prevention Program	Injury and Violence Prevention Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	7	6.5	6.5

Notes - 2009
Oregon Violent Death Reporting System data. Complete 2009 data not available, 2008 data carried forward.

Suicide deaths among young people aged 15-19 years of age seems to be raising steadily since 2006, reaching a high of 11.3/100,000 in 2008. However, trending should be interpreted with caution due to the 2008 data being provisional and differences in computation for 2007 and earlier. Reliability is also a concern with the population dropping dramatically in 2008 (247, 556) compared to 2007 (248,780).

Notes - 2008
The rate of suicide deaths among teenagers has increased steadily over the years from 6.2 per 100,000 in 2004 to 10.1 in 2008. However, given the infrequent nature of these events, this trend should be interpreted cautiously.

Notes - 2007
Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments
The Youth Suicide Prevention (YSP) program was in its third year of grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA)
for a Garrett Lee Smith Memorial Act grant (GLS). The Health Division, 3 regional/county sites (7 counties) and the Confederated Tribes of Warm Springs
Reservation continued to implement grant objectives, which included: increasing the number of gatekeeper trainers; increasing the number of people trained in
gatekeeper skills; implementing RESPONSE in high schools; increasing support for people impacted by suicide; working with local hospitals to develop surveillance
procedures to monitor trends and track services and outcomes for individual youth; and implementing culturally appropriate activities with the Confederated Tribes
of Oregon. The Confederated Tribes of Warm Springs built on previous Native HOPE youth trainings and conferences with leadership skills, cultural activities, and
mentoring. Tribal elders and other tribal adults attended a 2-day conference on youth suicide prevention.

The YSP program and GLS grant continued to evaluate our prevention efforts. The project evaluator analyzed pre, post, and follow-up survey data from QPR (Question, Persuade, Refer), ASIST (Applied Suicide Intervention Skills Training), & RESPONSE to compare outcomes. He presented the findings at two national conferences.

Together, the Southern Oregon and Lane County sites held a statewide suicide prevention conference. Speakers shared programs and outcomes and encouraged non-funded sites to become involved in youth suicide prevention. Speakers included tribal members, state public health program staff, evaluation experts, GLS grant site prevention coordinators, an Oregon National Guard chaplain, representatives from the Oregon College/University consortium on suicide prevention, and others.

Lane County held an Assessing and Managing Suicide Risk (AMSR,) training for mental health professionals who wanted training beyond ASIST. About 75 professionals attended. AMSR is on the Best Practice Registry.

The YSP Coordinator collaborated with NARA (Native American Rehabilitation Association) and Oregon tribes on youth suicide prevention activities. She attended the quarterly tribal members for prevention coordinators and worked with NARA's GLS project director. The Health Division provides Oregon Healthy Teen data to NARA"s project evaluators.

The YSP program received word in September 2009 that it had been awarded a second 3-year GLS grant. The current GLS grant is in a no-cost extension year.

The YSP program worked with the National Guard to increase intervention skills training and to prevent suicides through the Guard, their reintegration teams, and their family support services networks.
The YSP program worked closely with epidemiologists in Injury Prevention and the Oregon Violent Death Reporting System to discover trends and use data to inform planning and activities. We also worked together as members of Oregon's Child Fatality Review Team, providing information on youth suicides and suggesting prevention strategies. We began a public health investigation of a cluster of youth suicides that occurred in Southern Oregon.

The YSP coordinator presented the RESPONSE program at the annual GLS grantees meeting. She also presented data and information about suicides, prevention, and working with the Oregon National Guard.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Focus state and local efforts on best practice and evidence-based practices described in the State Suicide Prevention Plan.				X
2. Provide and facilitate training for providers, counselors, educators, and others on youth suicide prevention strategies.		X		X
3. Assess and monitor trends in youth suicides and suicide attempts through surveillance and participation on the State Child Fatality Review Team				X
4. Train school teams to implement RESPONSE in high schools as part of the Garrett Lee Smith Memorial Act (GLS) grant from the Substance Abuse and Mental Health Services Administration		X		X

(SAMHSA).				
5. Increase capacity in suicide intervention skills training throughout Oregon to crisis responders, clinicians, school staff, parents, and lay people as part of the GLS grant.		X		X
6. Encourage and support Bereavement Support activities.				X
7. Provide a medium for exchange of research findings, trainings, collaboration, news, and local events through a statewide listserv.			X	X
8. Educate the media on prevention and provide nationally-developed guidelines to increase safe reporting of high-profile suicides.			X	X
9.				
10.				

b. Current Activities

The YSP program is implementing the 3-year GLS grant that began September 30, 2009. The Project includes contracts with alcohol and drug prevention coordinators in 14 counties and engages Oregon's 9 Indian tribes in youth suicide prevention activities. These contracts will help to increase awareness of suicide as a preventable public health problem. The counties will train at least 4 new trainers each in QPR and ASIST over the 3 years of the grant, hold QPR and ASIST trainings, implement RESPONSE into the 39 schools that committed to the program, and implement "public awareness campaigns" twice a year. The tribes will hold a week-long campout for youth from all the tribes to prevent suicide and increase their protective factors.

The YSP will lead a process to determine the feasibility of offering QPR online to other state office staff, including juvenile justice, child welfare, mental health, and foster care.

There are 2 ASIST training for trainers scheduled in Oregon in April and July, in part to accommodate the number of counties who want to have new trainers trained. Several counties are getting QPR trainers who are bilingual in Spanish, including Lane County, which has worked closely with the Hispanic community to deliver QPR trainings.

The YSP will collaborate with with the University of Oregon, Lane and Benton Counties, and other state agencies to hold a prevention conference in September.

c. Plan for the Coming Year

YSP will continue implementation of the GLS grant and provide oversight and technical assistance to the local GLS sites, adding add 7 more counties to the GLS sites with additional funding for years 2 and 3 of the grant. Additionally, YSP will coordinate grant activities with NARA, another recipient of GLS funds.

The YSP will assist select counties to reach out to Hispanic communities in youth suicide prevention, including holding focus groups to hear the best ways for outreach.

Pre-, post-, and follow-up evaluations will be conducted of students in schools who participate in RESPONSE in Multnomah County, the state's most urban county.

An epidemiologic investigation will be conducted about a cluster of suicides in Southern Oregon.

Meetings with local hospital EDs, public health, and mental health will help determine follow-up referrals and access to care by youth who have attempted suicide
and their families. Enter and analyze data from the Adolescent Suicide Attempt Data System.

For training in suicide prevention, the YSP will conduct a comparison evaluation of outcomes between regular QPR trainings with an enhanced QPR that includes
role plays; support broader efforts in Oregon to implement RESPONSE; facilitate increasing the number of QPR trainers and trainings available throughout Oregon,
including trainings in Spanish to Hispanic communities and groups; and facilitate increasing the number ASIST trainers and trainings available throughout Oregon.

YSP Coordinator will provide support and provide technical assistance to local coalitions and youth suicide prevention efforts throughout Oregon.

Collaboration with the Regional Research Institute, Macro, and GLSMA sites will evaluate youth suicide prevention programs, including enhanced follow-up
evaluation of selected trainings and a qualitative study.

Collaborations with the Adolescent Health Section in OFH, the Addictions and Mental Health Division, the Tribal Liaison, the Children and Families Divison, and the
Oregon Youth Authority will support goals to increase awareness about youth suicide prevention and to collaborate on population-based strategies.

YSP will keep public information up to date by delivering presentations, administering the regional Youth Suicide Prevention Network (YSPNetwork) listserv,
maintaining updated statistics, data and fact sheets, and maintaining the YSP website.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	81	99	99.5
Annual Indicator	79.1	75.7	99.2	99.4	99.8
Numerator	375	368	491	484	471
Denominator	474	486	495	487	472
Data Source				Oregon Center for Health Statistics	Oregon Center for Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.8	99.8	99.8	99.8	99.8

Notes - 2009
Oregon Vital Statistics Data. Oregon does not have designated high risk facilities. Data since 2007 is based on very low birthweight infants born in hospitals.

Interpretation of data for this measure is limited due to change in methods of between 2006 and 2007.

Notes - 2008
Oregon does not have designated high risk facilities, Data from 2007 forward is based on very low birthweight infants born in hospitals. Previous years based on very low birth weight infants born at the 6 Oregon hospitals with NICUs.

Notes - 2007
Source: Hospital Discharge Data, 2007.

Previous year reported from 6 hospitals with NICUs. 2007 data is reporting from all hospitals and birthing centers.

Oregon does not have designated high risk delivery facilities, so numerator is based on very low birthweight infants born in hospitals.

a. Last Year's Accomplishments
Note on the data: For the years 2004-2006, data was reported from 6 hospitals with NICUs. From 2007 the data is from all hospitals and birthing centers. Oregon does not have designated high risk delivery facilities, so numerator is based on very low birthweight infants born in hospitals.

- There are 56 hospitals in the state that provide obstetric care. Seven have NICUs. In Oregon, there is no regulated designation for an NICU. The NICUs are staffed with Neonatologists and are Level III by the AAP Perinatal Levels of Care. The Oregon NICUs are: Providence St. Vincent's, Legacy Emanuel Hospital , Doernbecher Hospital NICU (OHSU) all in the Portland Metro area;, Salem Hospital in Salem, Sacred Heart Medical Center in Eugene, Rogue Valley Medical Center in Medford, and St. Charles Medical Center in Bend.

- OHSU provided consultation to providers caring for high risk deliveries & neonates, funded in part by OFH.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Advocacy for assuring systems in place to appropriately care for VLBW infants				X
2. Assessment and surveillance of status of VLBW infants among all population groups			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Oregon, a primarily rural state, believes women in pre-term labor should be transported to the nearest facility, not to a facility that is experienced in the care of very low birth-weight neonates that often requires long distance travel to the urban center (Portland or Eugene).

- OHSU provides consultation to providers caring for high risk deliveries & neonates, funded in part by OFH.

- The OCCYSHN CaCoon Nurse Consultant attends weekly rounds in the NICU at OHSU and communicates updates on resources to discharge coordinators in the other NICUS around Oregon

- OCCYSHN is developing a public health nursing webpage that will replace the web portal that was formerly used to inform providers about resources.

c. Plan for the Coming Year

- OFH continues to consider the feasibility of implementing statewide local Fetal Infant Mortality Review (FIMR). FIMR can be used to assess plan, improve and monitor service systems as well as broad community resources that support and promote the health and well-being of women, infants, and families. Information from FIMR will inform this performance measure as well as other positive system improvements to assure healthy Oregon Families.

- OCCYSHN will continue working on the development of a public health nursing webpage which will include information on the care of premature and high risk infants in the community

- OCCYSHN will offer several webinars on the care of children with special health care needs.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	82	82	80
Annual Indicator	81.0	79.2	78.4	70.6	71.5
Numerator	36610	38475	38484	33507	32584
Denominator	45195	48559	49078	47464	45560
Data Source				Oregon Center for Heatlh Statistics	Oregon Center for Heatlh Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	72	74	75	75	78

Notes - 2009
Vital statistics data, available: www.dhs.state.or.us/dhs/ph/chs/data/finalabd/09/birthpc.pdf.

Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008, resulting in a change in how prenatal care begin month is calculated. Several variables were used to determine whether a pregnant woman had received "adequate prenatal care" in the first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation. Due to change in tracking method and difference in computation, rates from 2008 and onward are not comparable with those from 2007 and earlier. 2008 data will be used as baseline.

Notes - 2008
Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. Several variables will be used to determine whether a pregnant woman had first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation and therefore, 2008 data is not yet available.

In recent years, there has been a small decrease in the percentage of women who have received prenatal care beginning in the first trimester, from a high of 81.0% in 2004 to a low of 78.4% in 2007.

Source: Oregon Center for Health Statistics. Preliminary 2008 data. Final data will be updated when available.

Notes - 2007
Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments
In 2007, Oregon ranked 33rd in the nation for adequacy of prenatal care (United Health Foundation America's Health Rankings, 2008). However, the OHSU Women's Health Report Card ranks Oregon 37th in the country for first trimester care (based on 2003 data). Presumptive eligibility facilitates early entry into prenatal care by guaranteeing that care delivered before OHP eligibility is formally established will be reimbursed. Women in Oregon often cannot see a prenatal care provider until the source of payment for care is determined because providers are reluctant to initiate care without having OHP or other coverage confirmed. As of 2007, presumptive eligibility was the Medicaid practice in 29 states (National Academy for State Health Policy, 2009).

Oregon MothersCare (OMC), a statewide initiative to improve access to early prenatal care, provided services at 29 sites in an effort to link women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds.

The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a toll-free hotline (SafeNet), a referral and support system for prenatal services, including dental services, and an ongoing public awareness, outreach, and education campaign. During 2009, the program assisted 5,202 women in gaining access to prenatal services.

The Office of Family Health (Title V Program) continued to provide funding and administered Maternity Case Management (MCM) and home visiting services through local health departments as part of an effort to increase access and effective utilization of prenatal care and other services to women without public or

private insurance.

Title V and Medicaid worked in partnership with local public health departments to implement the Prenatal Expansion Project to provide undocumented women with prenatal and dental care through the Citizen-Alien/Waived Emergency Medical (CAWEM) prenatal services pilot project. The program offers undocumented women health insurance coverage similar to Medicaid coverage for pregnant citizens. Initially a pilot project in two counties, the program is now in five counties statewide with more participation expected in the coming year.

The Office of Family Health also funded and administered the SafeNet contract to provide and MCH warmline to assist pregnant women to access prenatal care services in their community

OFH administered and analyzed the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach and link women to early and adequate prenatal care		X	X	
2. Maternity case management and home visiting services for high risk pregnant women		X	X	
3. Reproductive health and family planning services provide education about optimal prenatal care		X	X	
4. ORCHIDS client data system provides data to assess status of client risk factors and needs				X
5. PRAMS surveillance provides information about utilization, access, and quality of prenatal care				X
6. Advocacy for early prenatal care system and quality improvements				X
7. WIC and Family Planning programs refers women screening positive for pregnancy		X	X	
8.				
9.				
10.				

b. Current Activities

Oregon MothersCare (OMC) continues to link pregnant women to prenatal services in 30 sites serving 26 counties.

The Office of Family Health (Title V Program) continues to provide funding and to administer Maternity Case Management (MCM) and home visiting services through local health departments to help increase access and effective utilization of prenatal care and other services to women without public or private insurance.

The Office of Family Health is collaborating with the newly formed Medicaid Office of Healthy Kids to enroll all children in public or private health insurance. Pregnant women under age 19 with incomes up to 200% FPL are now eligible for Medicaid. Approximately 200 application assisters joined the Healthy Kids program to enroll children and families, in addition to the existing enrollment sites. The Office of

Family Health will continue to work with the Office of Healthy Kids to decrease barriers to Medicaid enrollment for all populations.

The Office of Family Health continues to fund and administer the SafeNet contract to provide an MCH warmline to assist pregnant women to access prenatal care services in their community

OFH administers and analyzes the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning.

OFH works in partnership with local health departments to align prenatal nurse home visiting programs with evidence based models and components.

c. Plan for the Coming Year

Continue to update and re-vitalize Oregon MothersCare (OMC) to improve access to early prenatal care, and dental care, assist local health departments and other OMC access sites to: formalize partnerships with prenatal care providers and other providers offering pregnancy related services, promote SafeNet, the toll-free hotline for referrals to local prenatal services; streamline systems for accessing care; and assist women to obtain a pregnancy test, OHP, a prenatal care provider, and WIC, maternity case management or other pregnancy services.

OFH will be working with local health departments to assure that the funding formula and quality assurance structure for Oregon MothersCare maximizes the reach of the program to assist pregnant women to access early prenatal care.

Collaboration and support will continue with community-based efforts to increase access to prenatal care and improve birth outcomes.

Health reform will provide additional opportunities and funding to improve perinatal health and outcomes. The public health homevisiting program will be restructured to focus on pregnant women and to provide a continuum of care. The home visiting model will be built on best practices and standardize MCH home visiting across the state.

A simpler Medicaid application process will decrease barriers to first trimester prenatal care. The Office of Healthy Kids will expand its focus on quality and efficiency for the Medicaid outreach and enrollment process across all populations in 2010/2011. OFH will partner to assure the needs of pregnant women are included in this effort and prioritized.

A new SafeNet Hotline contract will be implemented which includes enhanced data collection and referral services for women who call the warmline seeking prenatal care.

The Office of Family Health (Title V Program) will continue to provide funding and to administer Maternity Case Management (MCM) and home visiting services through local health departments. At the same time, OFH will work with local public health partners to revise the home visit nursing programs to prioritize evidence-based prenatal services, and will apply for enhanced Federal home visiting funds as those become available.

OFH will continue to administer and analyze the PRAMS survey of post-partum women to collect

information related to prenatal care access for surveillance and program planning.

D. State Performance Measures

State Performance Measure 1: *Percent of births where mothers report that the pregnancy was intended*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		62.7	63	63.4	63.8
Annual Indicator	62.0	62.1	60.6	59.4	59.4
Numerator	28456	30025	28571	27897	27897
Denominator	45905	48336	47183	46974	46974
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	63.8	63.8	64.5	64.5	

Notes - 2009
2009 not yet available, 2008 data carried over.

2008 shows that 59.4% of new mothers reported that their pregnancy was intended; this is a decrease of 1.2 percentage points from 2007, which showed that 60.6% of new mothers reported their pregnancy as intended.

Notes - 2008
Most recent data is weighted PRAMS data, 2007, carried over for 2008. Data indicate a small decline in pregnancy intendedness, from a high of 62.9% in 2004 to a low of 60.6% in 2007. All numbers are below the Healthy People 2010 objective of 70%.

Notes - 2007
Source: Weighted 2007 PRAMS data

a. Last Year's Accomplishments
In calendar year 2009, the Oregon Family Planning Program served 61,974 clients in clinics supported by Title X and Title V funds preventing an estimated 11,300 unintended pregnancies. An additional 46,221 Oregonians received family planning services through clinics participating in the Medicaid waiver Family Planning Expansion Project (FPEP). A total of 104,088 female clients were served, representing approximately 45% of the estimated Women in Need (WIN) supplying publicly-funded contraceptive services and supplies in Oregon.

In addition to contraceptive services provided and pregnancies averted, these clinical programs provided basic preventive health care services and exams for 108,195 women and men. Over 40,000 Pap smears and 43,00 clinical breast exams were done in family planning clinics.

Family planning clinics continued to face financial challenges caused, in part, by static Title X funding. Further, the FPEP eligibility changes (especially around citizenship documentation) have been a particular hardship for clinics supported by Title X funds. As a condition of their federal funding, these clinics must provide

services to anyone seeking care, regardless of that person's ability to pay. Clients who no longer qualify for FPEP must still be seen and their income levels generally qualify them for free or substantially discounted services. The result is that these clinics must somehow meet the same level of client need while operating with significantly less revenue.

Research on the impact of the FPEP eligibility changes (including documentation of citizenship) has demonstrated a 33% decline in client numbers between 2005 and 2008. Further analyses of family planning visits by time period and payor has demonstrated that teenage and African American clients have been particularly affected by the eligibility changes, with a 47% decline in visits among teenage clients and a 49% decline in visits among African American clients.

Continued ongoing quality assurance activities, including on-site evaluations of local family planning clinics, reviews of grant program annual plans, and FPEP chart audits to determine appropriateness of services billed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family planning and reproductive health programs provide preventive clinical services for all women		X		
2. Training and education for clinic staff to ensure that providers are up-to-date on clinical information and techniques, best practices in client counseling and education, and program requirements				X
3. Outreach and referral in communities to increase access and utilization of family planning services		X		
4. Technical assistance and training for clinic quality improvement				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

It is estimated that over 11,000 unintended pregnancies were averted in 2009 because of services provided in Title X and Title V MCH-supported clinics. Our goal is to maintain current resource levels so as to continue providing family planning services to low-income Oregonians.

In order to increase client volume at family planning clinics, a statewide FPEP media campaign, including transit ads, movie theater-screen ads, and billboards, was implemented in early 2009 and continues through 2010. In May 2010, this outreach campaign will be followed by a social marketing campaign utilizing web 2.0 technology, including social networking sites and an interactive website, to reach 19-29 year olds in need of family planning services.

Priority requirements continue to be implemented by the Title X program, including increasing involvement of male partners in family planning services,

encouraging family participation in the decisions of minors seeking family planning services, promoting highly effective birth control methods, and providing counseling to minors on how to resist coercion into sexual activities

c. Plan for the Coming Year

Continue to work with agencies to support clinics despite lack of revenue. Many agencies have had to limit clinic hours, close clinic sites, lay off staff and eliminate walk-in appointments.

Expand services covered by FPEP and raise federal poverty level (to 250% FPL which matches Title X FPL levels) for FPEP eligibility. These changes, by increasing the number of clients and services covered by FPEP, can be expected to relieve clinics of much of the financial burden placed on limited Title X funds.

Focus on FPEP outreach and social marketing efforts to increase the number of clients utilizing family planning services.

Continue to offer trainings and resources on clinic efficiencies to family planning clinics.

State Performance Measure 2: *Percent of smoking women who quit smoking during their pregnancy and did not begin smoking postpartum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		57.9	64	64.5	64.5
Annual Indicator	63.6	52.0	64.6	68.1	68.1
Numerator	2232	2501	3265	2767	2767
Denominator	3508	4807	5054	4064	4064
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	

Notes - 2009

2009 not yet available, 2008 data carried over.

2008 showed that 68.1% of women who quit smoking during their pregnancy did not begin smoking again post partum; this is an increase of 3.5 percentage points from 2007 (64.6%)

Notes - 2008

From weighted 2007 PRAMS data. PRAMS 2008 data is not yet available, so 2007 data is carried over.

The percent of women who quit smoking postpartum and did not begin smoking postpartum has had large swings in recent years, from a high of 64.6% in 2007 to a low of 52.0% in 2006. However, given the small sample sizes and large confidence intervals associated with this measure, these percents are not statistically different from one another. The 52.0% in 2006 has a 95% confidence interval that ranges from 39.8%-64.2% and the 64.6% in 2007 has a 95% confidence interval that ranges from 52.4% and 76.7%.

Notes - 2007

Source: Weighted PRAMS data, 2007.

a. Last Year's Accomplishments

Note: State Performance Measure 2 complements National Performance Measure 15, though NPM 15 focuses on cessation during the last 3 months of pregnancy.
For purposes of research and comparisons of individual measures with other states or nationally, strategies and activities for both measures are replicated in the
narratives for both measures in the Title V Information System.

Perinatal Health Program continued cessation screening and counseling in county services for family planning, prenatal care and Maternity Case Management
(MCM), nurse home visiting for high risk infants, and WIC.

State Public Health Division implemented an Environmental Protection Agency (EPA) grant award for "Building Capacity to Address Environmental Exposures
During Pregnancy." As a collaborative effort between the Office of Family Health (Title V) and the Environmental Health Section within the Public Health Division,
the pilot project has been implemented in two county health departments.. The project is piloting the development and use of an environmental home assessment
tool that contained a component addressing prenatal exposure to second and third-hand tobacco smoke.

Partnerships between DMAP, OFH, and local providers and agencies provided training, information, and education on the 2008 DHHS Clinical Practice Guidelines on
smoking cessation in local MCM and prenatal care services;

OFH conducted continuous quality improvement to improve ORCHIDS/MDE reporting on tobacco use and cessation during pregnancy and ensure validity of reports
for program evaluation and population surveillance.

PRAMS and PRAMS 2 collected and analyzed surveillance data on tobacco use in pregnant women as well as mothers with a 2-year-olds

The OFH state MCH Nurse Team provided a series of trainings to local county health nurses on 5A's for smoking cessation and Motivational interviewing during May
and June 2009. There were a total of 8 offerings in locations statewide (Baker, 3 in Multnomah, Deschutes, Josephine, Lane and a final one here at the PSOB).
Guest speakers were John Perkins and Karen Dluhosh from the Center for Health Training in Seattle. All counties with the exception of 4 attended. Total
attendance was 135, comprised of PHNs, a few Family Support Workers from Healthy Start and State Nurse Consultant staff.

PH nurses around the state delivered tobacco education and 5-A's quitting support to pregnant women through home visiting maternity case management visits.

The Oregon Tobacco quitline implemented a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with
specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and technical assistance to local MCM		X		X

providers on the Five A's Intervention and motivational interviewing for pregnant women				
2. PRAMS-2 (2-year old PRAMS follow up) data surveillance to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.				X
3. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
4. Health education and social marketing about smoking during pregnancy through Family Planning and Babies First home visiting program services			X	
5. Screening and referral in Babies First, WIC and Family Planning client services		X		
6. ORCHIDS (Oregon Child Health Information Data System) state and local level data reports on reported tobacco exposure during pregnancy and home visitor interventions to evaluate trends and level of intervention provided in MCH programs.				X
7. Pilot Project in two Oregon local health departments addressing environmental exposures during pregnancy including cigarettes and second hand smoke.				X
8.				
9.				
10.				

b. Current Activities

The 5As brief intervention for smoking cessation is now a required component of the MCM program and is included in the current 09-10 MCM Oregon Administrative Rules, OAR 410-130-0595.

Cessation screening and counseling is also continuing to be offered through county services for family planning, prenatal care, and nurse home visiting for high risk infants, and WIC.

Surveillance of perinatal tobacco use and cessation continues through PRAMS and PRAMS 2.

Monitoring and evaluation of county client data reports from ORCHIDS is being used to provide quality improvement for nurse home visiting services related to tobacco use in pregnancy, and to plan future programming by state and local partners.

The Oregon Tobacco quitline is continuing to provide a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

State Public Health Division continued implementation of the Environmental Protection Agency (EPA) grant award for "Building Capacity to Address Environmental Exposures During Pregnancy." The project is piloted the development and use of an environmental home assessment tool that contained a component addressing prenatal exposure to second and third-hand tobacco smoke. The project was completed and a final report submitted in April 2010

c. Plan for the Coming Year

Partnerships will continue with DMAP, local providers and agencies train and educate public health providers on perinatal tobacco issues, the use of the 5 A's
protocol and the 2008 revised DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

Cessation screening and counseling in county services for family planning, prenatal care and Maternity case management nurse home visiting for high risk infants,
and WIC will continue during 2011.

The Oregon Tobacco quitline will continue to provide a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit
Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

Evaluation of county client data reports from ORCHIDS will improve surveillance and monitoring on tobacco exposure during pregnancy and provider interventions.
The information will be used by the Perinatal Title V Program to plan for strategies in program services delivered by county health department partners.

Surveillance of perinatal tobacco use and cessation will continue through PRAMS and PRAMS 2.

State Performance Measure 3: *Percent of infants diagnosed with hearing loss that are enrolled or in Early Intervention before 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		53.4	54	54	55
Annual Indicator	40.7	34.7	49.2	31.4	45.7
Numerator	24	25	29	22	32
Denominator	59	72	59	70	70
Data Source				Oregon EHDI Program	Oregon EHDI Program
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56	57	58	58	

Notes - 2009
2008 & 2009: Numerator= children enrolled into EI by 6 months; Denominator= children diagnosed with hearing loss by 6 months based on national standard.

Interpretation is limited. Data for 2008 and after are not comparable with data for 2007 and earlier due to differences in computation. For example, the time frame for enrollment into EI and age of hearing loss cannot be verified.

Notes - 2008
2008 marks the first time that more than 50% of infants diagnosed with hearing loss were enrolled in early intervention before 6 months of age. However, this measure should be interpreted with caution as both the numerator and the denominator are relatively small, making the measure prone to fluctuation.

Notes - 2007

Source: Oregon EHDI Program

a. Last Year's Accomplishments

EHDI worked with the Audiology Best Practices subcommittee to sponsor pediatric audiology training. The training focused on pediatric audiology best practices to ensure that appropriate testing is conducted and to cultivate individuals throughout the state proficient in the necessary diagnostic testing methods.

The EHDI Parent Program trained and hired 9 regional parent guides throughout the State to support and mentor parents who have children that are diagnosed with hearing loss. This program reaches out to the rural communities to expand the level of service, information, and technology available to them and their children.

Through a collaborative partnership with midwives and stakeholders, EHDI continues to oversee three free hearing screening clinics to address the out-of-hospital birth population as well as smaller non-mandated hospitals.

Ongoing data collection and referrals were made on infants needing follow up and services for hearing loss. EHDI worked closely with diagnostic audiology centers and early intervention programs to ensure timely diagnosis and enrollment in early intervention for infants with hearing loss. The EHDI Advisory Board met quarterly and revised Early Intervention referral protocols to include unconfirmed loss. The EHDI Program continued to send status reports to each county Part C program to monitor the status of infants referred to EI for hearing loss.

A Pediatric Hearing Health Care survey was conducted to evaluate services throughout the State. The survey results emphasized the need for more training for audiologist regarding pediatric testing and hearing aid fittings.

A Hospital Survey and Training was conducted in November 2009 to coordinate hospital screening protocols and reporting. The survey revealed the need for ongoing training and site visits to support hospital newborn hearing screening programs and to address staff turnover and changes to the recommended protocols, based on the 2007 Joint Commission on Infant Hearing recommendations.

EHDI staff continued to contact families, medical home providers and local public health agencies to assist families in navigating the system. Referrals to Oregon's Children with Special Health Care Care Coordination (CaCoon) nursing program will continue for all infants identified with hearing loss.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnerships with Department of Education/EI programs to improve referral and eligibility process				X
2. Educate primary health care providers about the importance of timely early intervention services				X
3. Maintain an update list of Early Intervention programs and provide to diagnostic centers and health care providers				X
4. Increase referrals to Children with Special Health Care Needs Nursing Program to assist families in receiving timely intervention services		X		X
5. Continue to be single point of referral for birth to three year		X		X

olds with hearing loss to Early Intervention programs				
6. Improve Parent-to-Parent Support for parents with children with hearing loss.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

The State EHDI Program in the Office of Family Health continues to: ensure that infants with hearing loss are enrolled and receiving EI services before 6 months of age; make EI referrals directly to Part C for infants diagnosed with hearing loss; send reports to EI programs regarding the status of infants referred to their program.

EHDI is currently working with Pacific University to establish an audiology degree program in Oregon, projected to begin in 2012. The establishment of this program will help address the shortage of pediatric audiologists and the lack of this degree program in the State.

The EHDI Program continues to operate its loaner hearing aid bank, providing easy access to loaners for all infants birth to three years of age who are enrolled in EI Programs.

In January 2010 the program began piloting the use of the Vital Statistic Registry as a means to collect hospital hearing screening information. The pilot has resulted in more accurate demographic data reported in real time and it is anticipated that this will improve the program's ability to follow up with families and providers on infants who do not pass.

EHDI has established a Spanish Language line that is checked daily by a native Spanish speaker and can work with families to educate them about the testing process.

c. Plan for the Coming Year

EHDI plans to improve access for the uninsured population that does not have access to the necessary diagnostic testing. A contract with Oregon Health Science University was established , in the next year, audiologists will travel to rural counties and serve the uninsured population as well as train local audiologists to perform the testing.

The program plans to expand the current pilot for collecting hearing screening data through the birth certificate registry to all hospitals in the state. In addition, the program will develop web based reporting capabilities for diagnostic centers and working on electronic transfer of information between EHDI and the Part C Early Intervention programs.

EHDI will also continue to provide annual training forums for pediatric audiologists and hospital newborn hearing screening programs. The program will continue to send follow-up letters to providers and parents and conduct Early Intervention referrals for infants who have a diagnosed hearing loss.

State Performance Measure 4: *Percent of children that complete the 4th DTaP vaccine between 12 and 18 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		68.5	69	69.5	70
Annual Indicator	65.1	65.7	66.2	67.4	70
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70.5	70.5	71	71	

Notes - 2009
NIS does not report numerators or denominators.

There has been a gradual trend upward from 2005 to 2009 in the percent of children 12 to 18 months who have completed the 4th DTap vaccine.

Notes - 2008
No significant change has occurred in the 4th DTaP completion rate of among Oregon 12 to 18 month old children. 2008 data is not available.

Notes - 2007
National Immunization Survey, 2007 data; survey does not report numerators and denominators.

a. Last Year's Accomplishments
The Immunization Program provided guidance for local health departments to assist their annual planning efforts on improving 4th DTaP rates in their communities.

Coverage for the fourth DTaP dose is the lowest among primary childhood vaccines while Pertussis is increasing in Oregon. The Immunization Program collaborated with Acute and Communicable Disease Program to assess the incremental effectiveness of the fourth DTaP dose in preventing Pertussis and found that it did not offer additional protection among Oregonians. Sought national partners to substantiate findings, and found that additional research is needed to determine if it
lessens disease severity.

Continued working with local health departments and private providers to focus quality improvement efforts on increasing the timely administration of 4th DTaP. The Immunization Program leads this process by completing immunization assessments that measure up-to-date rates and clinic practices that affect those rates. Then feedback was provided to clinic staff to help identify opportunities for practice change to increase shot rates.

Promoted Pertussis prevention through articles, fact sheets, educational materials, and speaking opportunities on the family and community impact of Pertussis.

Population-based immunization rates were provided to counties and partners to assess timely administration of 4th DTaP and other vaccines.

Educational materials and current literature were disseminated at Oregon Partnership to Immunize Children (OPIC) coalition meetings, statewide conferences and partner meetings.

Collaborated with DMAP to assess shot patterns at all childhood medical encounters to identify opportunities for increasing shot completion rates.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Communication Network established between Oregon and Washington state coalitions to share immunization information			X	X
2. Educational materials distributed through Communication Network and posted to websites			X	X
3. AFIX clinic assessments to provide education and performance feedback for providers		X	X	X
4. Local health departments using state funding to build on 4th DTaP in their communities – billboards, special outreach, special recalls	X		X	
5. Evaluation of medical encounter data to identify missed opportunities for completion of DTaP vaccine series			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The new Immunization Information System that combines ALERT and IRIS registries is being implemented and will improve support and forecasting for providers.

The Immunization Program will continue to provide assessment data, technical assistance, and financial resources to support LHD outreach and private provider increased rates of 4th DTaP vaccines.

Immunization Program will continue to partner with community groups to communicate the impact of Pertussis on families and communities and to ensure that all children have the opportunity to complete the DTaP immunization series.

Immunization staff are collaborating with federal and local health authorities to enhance Pertussis surveillance in order to better understand vaccine efficacy.

Reminder and recalls will be evaluated during the immunization information system platform change to assess key messages and timing of mailed reminders and recalls to parents/guardians of infants.

Develop ‘relevant rates' that tie shot uptake to disease incidence in Oregon communities

c. Plan for the Coming Year

The Immunization Program will continue to provide assessment data, technical assistance, and financial resources to support LHD outreach and private provider increased rates of 4th DTaP

vaccines.

Coalition outreach and education resources regarding 4th DTaP will continue to be provided to local partners.

The 'relevant rates' will continue in development to tie shot uptake to disease incidence in Oregon communities.

State Performance Measure 5: *Percent of 8th graders who report being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		75	75	70	73
Annual Indicator	59.0	59.0	56.2	58.3	57.5
Numerator	9063	2094	5016	6091	3035
Denominator	15363	3550	8928	10441	5277
Data Source				Oregon Healthy Teens Survey (YRBS)	Oregon Healthy Teens Survey (YRBS)
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	

Notes - 2009
2009 shows that 57.5 percent of 8th graders reported being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days; this is a decrease of 0.8 percentage points from 2008 (58.3%).

Notes - 2008
The numerator and denominator are not weighted in this table and represent the number of respondents, not the total population. Oregon Healthy Teens Survey (Oregon's Youth Risk Behavior Survey) is based on weighted percentages.
- For 2005, the correct numerator and denominator are 4,904 and 8,433 respectively. The weighted percentage is 57.9%.
- For 2006, the weighted percentage is 59.5%.
- For 2007, the weighted percentage is 55.7%.
- For 2008, the weighted percentage is 58.0%.

Notes - 2007
Source: Healthy Teens Survey, 2007.

a. Last Year's Accomplishments
The Office of Family Health is represented on advisory board for Oregon's Walk and Bike to School Day. The Adolescent Health Section (AHS) promoted Oregon Walk and Bike to School Day (Oct. 2009) and Walk and Bike Challenge month (May 2009). 192 Oregon schools and over 31,111 children, parents, school staff and community members participated in Walk and Bike to School Day.

OFH represented public health in Safe Routes to meetings and grant award discussions.

The AHS coordinated efforts with Healthy Kids Learn Better (HKLB), Alliance for Healthier Generations, and Oregon's Action for Healthy Kids Team to assist schools in assessing and implementing their School Wellness Policies -- including policies around PE, recess, and walking and biking to school.

Participated in School Wellness Award Recognition for evaluating physical activity school wellness policies as part of the overall award criteria

The partnership continued with Physical Activity Network, Kaiser Permanente, Oregon PTA, Multnomah County Libraries and the NW Media Literacy Center, Community Health Partnerships, OSU Extension and YMCA to sponsor Oregon's TV-Turnoff Week. The coalition staged and publicized a variety of events during the week, attracting participants throughout Oregon and SW Washington. In preparation for the event, the coalition published a wide variety of print media regarding TV-Turnoff Week and the potential effects of excessive screen time. Representatives from OFH contributed to the creation, promotion and distribution of more than 20,000 copies of TV-Turnoff and Screen Time Awareness materials, including a flyer created by several OFH members titled, "You Have the Power: 5 Steps to Guide Your Child's TV Time".

The OFH Physical Activity and Nutrition group continues to collaborate with the Office of Disease Prevention and Epidemiology (ODPE) to continue efforts around physical activity.

OFH along with ODPE's Health Promotion and Chronic Disease Program applied for ARRA grant funding to create statewide Worksite Wellness Policy Implementation.

Physical activity messages are a routine part of SBHC visits. The School-based Health Center program (SBHC) continued to develop goals on obesity prevention, physical activity and nutrition and BMI measurements.

The State WIC Program recommended a physical activity objective for WIC locals in local nutrition education plans. WIC worked to incorporate messages around physical activity into their one-on-one nutrition counseling.

OFH worked to provide resources on physical activity and nutrition to child care. For parents of young children, home visiting public health nurses promoted physical activity messages to promote growth and development, such as infant tummy time and appropriate screen time.

Local public health nurses taught parents activities to promote growth and development in their children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate Nutrition and Physical Activity across the Office of Family Health Programs, and Worksite Wellness Activities				X
2. Provide leadership and coordination of Walk and Bike to School Day and Walk and Bike Challenge Month for communities				X
3. Collaborate with Safe Routes to School programs				X
4. Assist WIC and Child Health with promoting TV-Turn Off Week and distributing materials				X
5. Assist WIC and Child Health programs provide education on limiting screen time				X

6. Compile and analyze state-level physical activity data from a variety of sources				X
7. Promote family-centered physical activity promotion activities when possible in state and local programs and policy efforts				X
8. Support population-based planning and policy efforts to include adequate daily physical activity.			X	
9. Support school staff in adopting and implementing school wellness policies that focus on physical activity within the school day		X		
10. Assist Schools (preschool-higher education) and child care to create and implement employee wellness, physical activity related policies		X		

b. Current Activities
OFH is working in collaboration with Chronic Disease Prevention Section to promote legislative policies based on the physical activity strategies listed in the statewide physical activity and nutrition plan.

OFH and Oregon's Chronic Disease Program are working on a joint-effort to create a Worksite Wellness Policy trainings and implantation in public and private worksites, schools, preschools, higher education, and childcare. The policies will focus on nutrition, physical activity, breastfeeding, and tobacco. These are part of the state non-competitive ARRA grant funding.

OFH programs are planning the 2010 Walk and Bike to School Day and May Challenge Month and encouraging year round walking and biking.

OFH participates with the state-wide coalition, Healthy Kids Watch Less TV.

OFH is working to continue getting information on physical activity and nutrition out to child care providers.

The Immunization program participated in 2009 TV-Turnoff Week by handing out promotional stickers through local immunization clinics. WIC developed activity cards to give to participants.

Youth Action Research Project in process this year where students chose to research barriers to eating school breakfast and lunch for students and school staff.

Collaborate with other agencies through Wellness in School Environments (WISE) to help schools implement school wellness policies that improve nutrition and opportunities for physical activity within the school environment.

c. Plan for the Coming Year
The OFH Nutrition and Physical Activity Workgroup will continue to meet and work on coordinating consistent messaging around physical activity and nutrition and integrating these messages into all OFH programs. This group will identify strategies listed in the recently released Oregon Physical Activity and Nutrition Plan 2007-2012 that can be incorporated into OFH/Title V programs' activities and shared with county health departments.

OFH programs will assist with planning the 2010 Walk and Bike to School Day, May Challenge Month and promote walking and biking activities throughout the year.

OFH will continue to collaborate with the Safe Routes to School programs.

The Adolescent Health nutrition consultant will continue to participate in the statewide coalition for

"Healthy Kids Watch Less TV" to promote the importance of limited screen time for children and families. The coalition will disseminate our "You Have the Power" handouts, and plan for 2011 TV-Turnoff Week with partners.

Work will continue to integrate physical activity messages and activities into OFH programs that have components for schools and young children. Surveillance of physical activity will be conducted with the new Elementary School Survey and other methods for collecting data to understand the extent of physical activity among school age children.

Collaborate with groups like Wellness in School Environments (WISE) to ensure that School Wellness policies and monitoring systems are in place.

The AHS physical activity consultant will collaborate to continue Worksite Wellness Trainings and Policy Implementation statewide, including promoting physical activity and an active, healthy life for Oregonians of all ages.

The OFH/Title V offices will continue partnership with the Chronic Disease Prevention programs, in the state Health Division, to promote strategies listed in the Statewide Nutrition and Physical Activity Plan (http://www.oregon.gov/DHS/ph/pan/index.shtml) that address the environments in which Oregonians spend their time and support physical activity in each socio-ecological level

State Performance Measure 6: *Percent of 11th graders who report having unmet health care needs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	29	29	28
Annual Indicator	33.5	28.1	28.6	27.7	29.4
Numerator	3527	724	1654	1942	1033
Denominator	10529	2576	5783	7001	3512
Data Source				Oregon Healthy Teens Survey (YRBS)	Oregon Healthy Teens Survey (YRBS)
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	27	26	26	

Notes - 2009
2009 data shows that 29.4 percent of 11th graders reported having unmet health care needs; this is an increase of 1.7 percentage points from 2008 (27.7%).

Notes - 2008
Oregon Healthy Teens Survey (Oregon's Youth Risk Behavior Survey) is based on weighted percentages; numerator and denominator are not weighted and represent the number of respondents, not the total population. Because of the change in survey question text between 2005 and 2006, there is a break in interpretable trend data. Between 2006 and 2008, the rate has been essentially unchanged, hovering around 28%.

- For 2005, the correct numerator and denominator are 2201 and 6676 respectively. The

weighted percentage is 33.5%.
- For 2006, the weighted percentage is 28.1%.
- For 2007, the weighted percentage is 28.9%.
- For 2008, the weighted percentage is 27.8%.

Notes - 2007
Source: Healthy Teens Survey, 2007.

a. Last Year's Accomplishments
OFH collaborated with the Health Promotion and Chronic Disease Prevention Program to maintain a public health focus for the Coordinated School Health Program. The Program supported the following activities:

- Leadership, training, and technical assistance to support implementation of a mental health focused Coordinated School Health Program
- Data gathering for the 2008 CDC's School Health Profiles Survey.
- Analysis of data to examine correlations between youth gambling behaviors and other health risks.
- Creation of an evaluation plan to examine the impact of school participation in Coordinated School Health with youth tobacco use rates.

Twelve School-Based Health Centers planning sites advanced to Phase II with the expectation of being state certified by June 30, 2009; three of the twelve sites are in counties without existing SBHCs. Eleven new certified SBHCs opened.

The SBHC Program and partners participated in a workgroup to reevaluate the current State funding formula, for recommendation to the Conference of Local Health Officials (CLHO).

The Adolescent Health program wrote and submitted a paper on youth Choking Game participation to the Morbidity and Mortality Weekly Report (MMWR) for review.

Adolescent Health worked on a pilot of collecting information about positive youth development indicators from youth-serving programs around the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Infrastructure funding and support for School-Based Health Centers				X
2. Technical assistance, training and funding for local School-Based Health Center planning				X
3. Support and technical assistance to build sustainability of local School-Based Health Centers				X
4. Consultation and technical assistance to assure certification of School-Based Health Centers				X
5. Data collection and evaluation of School-Based Health Center clients and visits				X
6. . Infrastructure funding for coordinated school health programs – Healthy Kids Learn Better (HKLB)				X
7. Technical assistance and planning with HKLB school sites				X
8. Data collection and evaluation of Coordinated School Health programs				X
9. Conduct the Oregon School Health Policy & Programs Survey				X

10. Participate on the Oregon Health Teens Survey (YRBS) Governance Group				X

b. Current Activities
The HKLB program will continue work with the N. Mental Health Project and development of the Healthy Kids Learn Better- Health Education Cadre

The SBHC program utilizes information from the Mental Health Needs Assessment Project and works with partners to provide technical assistance, training and system development in the area of emotional health. An article about the assessment results was published in the Advances in School Mental Health Promotion in April 2010.

The SBHC Certification process will span the biennium, and will be conducted by one individual to facilitate continuity and standardization of site visits and to reduce costs. The funding formula for fund allocation will also be revised. An assessment of local health authorities will be conducted to determine the feasibility of SBHC expansion in 2011-2013.

Thirteen sites in ten counties, including three counties without an existing certified SBHC were awarded SBHC Phase I Planning grants, with expected certification by spring 2011.

Adolescent Health worked on a policy proposal to extend health insurance coverage to older adolescents (age 18-25) by extending the age at which they are considered dependents, for insurance purposes, and allowing them to remain on parental coverage.

The choking game paper written by AH staff was published in the January 2010 issue of Morbidity and Mortality Weekly Report (MMWR) and will be followed up with a fact sheet for parents about prevention and warning signs.

c. Plan for the Coming Year
Adolescent Health (AH) will be publishing and distributing a guide explaining rules/laws about minor rights and confidentiality of health care services. The guide will be aimed at youth, parents and providers.

Adolescent Health will be analyzing the second year of choking game data from the Oregon Healthy Teens survey and assessing more links between participation and youth risk/protective factors.

Adolescent Health with be finalizing and distributing our policy white paper on health insurance and the young adult population, taking into account recent federal health reform.

AH will be collaborating with Oregon Center for Children and Youth with Special Health Needs on a 'youth summit' focused on transition issues for older adolescents/young adults with disabilities

AH will continue participation with the WRH section in our AMCHP action learning collaborative focused on preconception health for young adults with disabilities.

The School-Based Health Center (SBHC) program will continue to monitor progress of key performance measures in all certified SBHCs.

The SBHC program will continue to collect and maintain a statewide medical encounter and operations database to monitor, evaluate and report on SBHC services and utilization.

The SBHC program will continue with re-certification of existing sites and certify the Advance Phase Planning site.

The SBHC program will award Phase II Planning grants based on Phase I Planning Site report and activities and support Phase II planning site activities with the expectation to be certified by Spring 2011.

Participate in the National Assembly on School-Based Health Care Partnership Initiative to develop a regional training team, which involves partnering with the Oregon School-Based Health Care Network and Washington SBHCs to conduct statewide trainings.

Conduct cost and revenue analyses for Oregon SBHCs.

The SBHC Program will participate in and present posters at the annual National Assembly on School-Based Health Care Conference.

The HKLB program will follow up with and evaluate past HKLB schools to determine if schools that have been trained in Coordinated School Health still have functioning programs. We also will be working to identify technical assistance needs among these schools and respond accordingly.

The HKLB program will continue to partner with the Health Promotion and Chronic Disease Prevention Program on the Healthy Communities Initiative (formerly Tobacco Related and Other Chronic Disease Initiative). This initiative is designed to increase local public health capacity to address chronic disease prevention, early detection, and self-management across schools, communities, health systems, and work sites. HKLB is providing training support related to working with schools utilizing a coordinated school health approach.

State Performance Measure 7: *Percent of Oregonians living in a community where the water system is optimally fluoridated.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27	28	21	21	21
Annual Indicator	20.3	27.4	27.4	27.4	27.4
Numerator	737549	839727	839727	839727	839727
Denominator	3631440	3069204	3069204	3069204	3069204
Data Source				CDC	CDC
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	21	21	21	21	

Notes - 2009
Oregon Drinking Water Program supplied by the Oral Health Program to CDC's/ASTDD's Water Fluoridation System.

Numerator: Population receiving optimally fluoridated water, including naturally fluoridated water
Denominator: Population served by public water systems

As of 6/7/10 2008 data not available, so 2007 data is carried forward for years 2008 and 2009. Data depends on how often CDC calculates and makes the data available to the public at http://www.cdc.gov/fluoridation/statistics/reference_stats.htm.

Notes - 2008

Oregon Drinking Water Program supplied by the Oral Health Program to CDC's/ASTDD's Water Fluoridation System.

Numerator: Population receiving optimally fluoridated water, including naturally fluoridated water
Denominator: Population served by public water systems

Data is not available for 2008 so continue to use 2006 data. Availability depends on how often the Drinking Water Program gets data from public water systems.

Previously reported data for 2004, 2005, and 2006 were incorrect. The correct percentages are 18.8% for 2004 and 2005 and 27.4% for 2006.

Notes - 2007
Oregon Drinking Water Program supplied by the Oral Health Program to CDC's/ASTDD's Water Fluoridation System.

Numerator: Population receiving optimally fluoridated water, including naturally fluoridated water
Denominator: Population served by public water systems

a. Last Year's Accomplishments
Note on the data: The Oral Health Program uses SDWSS data supplied to CDC's/ASTDD's Water Fluoridation Reporting System (WFRS). The most recent estimate, because actual figures very depending on how water systems report to the Drinking Water Program, is 27% of Oregonians are on water systems that are optimally fluoridated or adjust fluoride to optimal levels.

The Oral Health Program does not direct funding to support community water fluoridation efforts. However, the program does continue to provide technical assistance from local partners as needed and stays abreast of current trends, reports, and research findings at the national level.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocate for community water fluoridation through public education and policy development				X
2. Establish and provide technical assistance in the development of community coalitions				X
3. Collaborate with Oregon Drinking Water Systems to provide technical assistance to water districts			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Water Fluoridation Reporting System (WFRS) is a national database operated by the CDC. It allows users to look at fluoride information by water system in a state.

The PEW Commission on Oral Health released a report on state's performance in policy

development that supports children's oral health. Water fluoridation was identified as a key benchmark. Oregon received a grade C on the report and having a low state fluoridation rate was a contributing factor in that grade.

c. Plan for the Coming Year
In collaboration with the DHS Drinking Water Program (DWP), the Oral Health Program will continue to maintain Oregon data in the CDC Water Fluoridation Reporting System (WFRS).

The Oral Health Program will continue to provide technical assistance to local communities on technical and preventive aspects of fluoridating community water systems.

The Oregon Oral Health Coalition will continue to collaborate with the Healthy Smiles coalition in support of community water fluoridation.

State Performance Measure 8: *Percent of health care providers who report confidence in caring for CYSHN and their families*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	96	96
Annual Indicator	91.7	95.1	95.1	90.6	90.0
Numerator	166	137	137	164	297
Denominator	181	144	144	181	330
Data Source				OCCYSHN-administered training satisfaction surveys	OCCYSHN-administered training satisfaction surveys
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	

Notes - 2009
As described in the 2008 Notes, OCCYSHN implemented a new method for measuring provider confidence in caring for CYSHN. OCCYSHN embedded a question within its post-training evaluation survey asking providers who participated in an OCCYSHN-sponsored training to indicate the extent to which the training improved their confidence in caring for CYSHN. The following response options are provided for this question: Strongly Agree, Agree, Disagree, Strongly Disagree.

The denominator for this indicator (n = 330) represents the number of individuals who participated one or more of the 27 trainings offered by OCCYSHN during FY 2009. The numerator for this indicator represents the number of individuals who indicated that they Strongly Agree or Agree that the training activity improved their confidence in caring for CYSHN (n = 297).

In 2009, OCCYSHN offered several trainings via webinar. The use of webinar technology allowed

a greater number of providers to participate from all areas of the state. Compared to the previous year, OCCYSHN experienced a significant increase in the number of training participants (FY08 =181 vs. FY09=330). Although OCCYSHN is unable to show significant progress towards this indicator, the increase in training participants has resulted in an overall greater number of providers who report confidence in caring for CYSHN (FY08=164 vs. FY09=297).

Notes - 2008
As described in the 2007 Notes, in 2008 we implemented a new method for measuring provider confidence in caring for CYSHN. As a component of our post-training evaluation activities, we are asking providers who attend OCCYSHN-offered trainings to respond to a single survey item that asks they indicate the extent to which the training they attended improved their confidence in caring for CYSHN. The following response options are provided for this question: Strongly Agree, Agree, Disagree, Strongly Disagree. The denominator for this indicator (n = 181) represents the number of individuals who attended the 14 trainings offered by OCCYSHN during FY 2008. The numerator for this indicator represents the number of individuals who indicated that they Strongly Agree (n = 46) or Agree (n = 107) that the training activity improved their confidence in caring for CYSHN (n = 164).

While we feel that the method we implemented for 2008 provides us with a better approximation of the degree to which OCCYSHN training activities are contributing to progress toward this indicator, we are currently investigating other methods that will allow us to more globally assess the degree to which the broader health care provider community is confident in caring for CYSHN . We are currently reviewing options for using existing measures and the potential for creating a new measure to capture the concepts underlying the latent construct of confidence.

Note on data: An overwhelming majority of providers who participated in OCCYSHN-sponsored trainings during the prior fiscal year (84.5 percent) indicated that the training(s) in which they participated improved their confidence in caring for CSHCN.

Data Source: Data used to compute this indicator are from OCCYSHN-administered training satisfaction surveys. Surveys are administered following each training provided by OCCYSHN.

Notes - 2007
This represents a proxy measure of confidence. This is the number of providers trained of those "available" in the program year to train, including CaCoon Coordinators (45), Promotoras (4), community members of the Community Connections Network (42), CDRC clinicians (35), LEND Trainees (12) and our Family Liaison (6). Of the 144 providers who were availabe to receive training by OCCYSHN, 135 participated in training activities.

OCCYSHN is working to develop a measure of confidence of providing care to CYSHN.

The numbers reported for 2006 and 2007 are identical due to the fact that we inadvertently reported 2007 data in 2006. In 2008 we have begun to implement a survey item asking trained providers to indicate the extent to which they are confident in the care of CYSHN and their famlies.

a. Last Year's Accomplishments
OCCYSHN contributed to a confident and competent workforce through its statewide training programs. Ongoing training and supports continued for PHNs, CCN teams, and Family Liaisons. A 2-day statewide conference for 60 community providers was also sponsored. 92% of attendees were satisfied or highly satisfied with the conference. 94% strongly agreed or agreed that conference information increased their confidence in providing care for CYSHN.

Community consultants worked with local CCN teams and hospitals to provide 16 trainings and/or consultations on a wide variety of CYSHN topics. Community Consultants worked with OPS, CCN teams and hospitals to provide 5 Autism Screening Trainings to primary care providers in

local communities across Oregon. OCCYSHN also worked with local hospitals to offer providers Grand Round CMEs for autism screening trainings.

An online CCN Toolbox to increase access to resources, tips and promising practices on direct care, community trainings, improving systems of care, family-centered care and Medical Home was created and added to the OCCYSHN website.

OCCYSHN provided interdisciplinary seminars to LEND trainees on Learning Disabilities, Resources for Families, Interdisciplinary Assessment of the Family, Adolescent Transition, and Health Care Systems. Through the efforts of the Oregon ABCD Initiative, OCCYSHN worked with ODE and OFH to train primary care practices on use of a universal referral form to EI/ECSE. OCCYSHN also staffed a resource table at the 2009 Education + Medicine Conference to increase understanding of OCCYSHN programs and resources.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and technical assistance for providers of CYSHN through a variety of venues and formats				X
2. Develop and provide training to Family Involvement Network; support leadership training for families				X
3. Partner with agencies/associations to include topics of chronic conditions/special health needs on training agendas				X
4. Disseminate information on evidence-based best practice/promising practices		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN is continuing its statewide training program to meet the knowledge and skill needs of local providers and families around the state. Ongoing training and supports have continued for PHNs, CCN teams, and Family Liaisons. OCCYSHN also sponsored a statewide training for primary care providers entitled "Quality Improvement for Children, Youth with Special Health Needs -- From Policy to Practice".

OCCYSHN developed and facilitated 8 webinar trainings for CaCoon nurses, CCN teams, primary care and community providers. Staff archived the trainings and materials on the OCCYSHN web site. CCN Consultants worked with CCN Teams to provide 6 local trainings on CYSHN topics. CCN consultants also worked with local hospitals to offer providers Grand Round CMEs. This year, staff developed a new, consolidated evaluation tool for webinar and local trainings and revised annual survey for CCN teams. CCN consultants continue to survey on satisfaction, topics for future trainings and unmet needs of CYSHN and families and continue to develop the CCN Toolbox. A 2-day training for providers, educators and families in Klamath Falls was facilitated to address their needs relative to ADHD diagnosis, treatment and medical management.

OCCYSHN partnered with LEND to provide training to increase provider confidence and

competence in caring for CYSHN and provide distance training on Autism Screening and ADHD to rural areas. LEND trainees often participate in OCCYSHN sponsored webinars and trainings.

c. Plan for the Coming Year
This measure was developed at a time when OCCYSHN received additional federal funding through integrated services grants. With the ending of those funds, OCCYSHN has planned to retire this measure for the coming year. Despite the retirement of this measure, the following activities will continue through FY 2011:

To meet the needs of local providers and families around the state, OCCYSHN will continue statewide training programs, consultation and technical assistance. Ongoing training and supports will be continued for CaCoon PHNs, CCN teams, and Family Liaisons and other community providers. The CaCoon program will continue to use webinars to provide continuing education to CaCoon nurses, school-based nurses and ENCC'S. The CaCoon program will identify and develop other training opportunities as the CaCoon program redesign progresses. OCCYSHN will also continue to evaluate and improve webinar training program to better meet the needs of rural providers.

OCCYHSN plans to continue to partner with LEND on ID seminars and distance trainings and LEND trainee participation in OCCYSHN programs. OCCYSHN will also participate in community forums and educational events, either as leaders or as participants to share expertise and gather information with and for families and providers. OCCYSHN will continue to develop its website so that families and providers can easily locate needed information and tools.

State Performance Measure 9: *Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		65	65	86	86
Annual Indicator	62.3	62.3	85.5	85.5	85.5
Numerator	70694	70694	99990	99990	99990
Denominator	113418	113418	116988	116988	116988
Data Source				2005/06 NS-CSHCN	2005/06 NS-CSHCN
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	

Notes - 2009
As in 2008, data reported for this State Performance Measure are from the 2005/2006 NS-CSHCN. These are the most current data available for measurement of progress toward this indicator.

Note on data: Of the 85.5 percent of Oregon families who indicated costs not covered by insurance were either usually or always reasonable, nearly half (48.4 percent) indicated that these costs were usually reasonable and slightly more than half (51.6 percent) indicated these costs were always reasonable.

Data Source: Data used to compute this indicator are from the 2005/06 NS-CSHCN. The specific

item used to compute this information is C8Q01_B, as follows: “Are the costs not covered by (child’s name) health insurance reasonable? Response options for this item are Always, Usually, Sometimes, and Never.

Notes - 2008
As in 2007, data reported for this State Performance Measure are from the 2005/2006 NS-CSHCN. These are the most current data available for measurement of progress toward this indicator.

Note on data: Of the 85.5 percent of Oregon families who indicated costs not covered by insurance were either usually or always reasonable, nearly half (48.4 percent) indicated that these costs were usually reasonable and slightly more than half (51.6 percent) indicated these costs were always reasonable.

Data Source: Data used to compute this indicator are from the 2005/06 NS-CSHCN. The specific item used to compute this information is C8Q01_B, as follows: “Are the costs not covered by (child’s name) health insurance reasonable? Response options for this item are Always, Usually, Sometimes, and Never.

Notes - 2007
This year's report of State Performance #9 is derived from item C8Q01_B of the NS-CSHCN for 2005/2006. There is a slight variation in the item from the 2001 survey in that the response option "No out of pocket costs" was added which 7.9% of Oregon respondents selected.

a. Last Year's Accomplishments
OCCYSHN provided testimony regarding impact and cost data for a legislative bill mandating private insurance coverage of hearing aids for children. OCCYSHN staff joined forums to identify, track and provide information on health care access and finance issues.

OCCYSHN collaborated with several entities on projects related to adequate insurance coverage for CYSHN in rural areas. For example, OCCYSHN partnered with DMAP to identify issues related to care coordination and the challenges of families in rural areas. OCCYHSN also collaborated with OHSC and DMAP to staff commission's genetic advisory committee to identify genetic services coverage issues and make recommendations about changes in coverage. To train community partners about insurance issues and benefits counseling, OCCYSHN collaborated with the Oregon Insurance Division and Family Voices.

OCCYSHN completed several assessment and evaluation projects last year including analyzing cost and satisfaction data for genetics telemedicine visits, monitoring and tracking of telemedicine reimbursement legislation, and surveying ENCCs regarding their need for information and TA on care coordination of CYSHN. OCCYSHN also explored data sources for assessing the extent to which in-kind or charity care is delivered for CYSHN. An assessment of needs was conducted in select rural communities. The findings were analyzed and disseminated to key community partners. Ultimately, the findings served as catalyst to initiate a facilitated discussion and plan to respond to CYSHN needs within local systems of care.

FSP was unfortunately discontinued as a result of the redesign of the OCCYSHN program to integrate clinical and public health activities. However, OCCYSHN was able to provide financial assistance to families through the Zetosch gift fund.

OCCYSHN promoted Medical Home including use of insurance benefits, availability of services for the uninsured, and sliding scale costs for health care through FQHCs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Family Support Program to assist families with costs not reimbursed/paid by insurance or other funding		X		
2. Collect/analyze data related to out of pocket costs incurred by families				X
3. Educate/inform decision makers of the impact on families of out-of-pocket costs and needs for comprehensive coverage or additional funding for services, e.g. respite care				X
4. Provide information and education to families about maximizing healthcare and related benefits (CaCoon, CCN, partnerships with Family to Family Health Information & Education Ctr)		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This measure was developed at a time when OCCYSHN received additional federal funding through the Strengthening Oregon's Communities integrated services grant which allowed for greater capacity to address issues related to adequate health insurance. With the ending of those funds, OCCYSHN now reports several of its activities around adequate insurance within National Performance Measure #4. The following activities are specific to this performance measure:

Through efforts of the Oregon Medical Home Initiative, OCCYSHN continues to train community partners in rural areas about coverage. CaCoon nurse consultants and CCN consultants continue to work with ENCCs and other community partners to identify methods for addressing the insurance needs of CYSHN. Data collected through the CaCoon and CCN programs is currently being assessed to identify community needs. Data findings are being shared with communities to facilitate discussions and explore opportunities for community activities.

OCCYSHN continues to partner with DMAP to identify issues related to care coordination and challenges of families in rural areas. Through partnerships with state agencies and other key entities OCCYSHN is exploring potential data sources for assessing the extent to which in-kind or charity care of CYSHN is delivered.

OCCYSHN continues to administer the Zetosch gift fund to assist families in meeting the education-related needs of their children with special health needs and disabilities.

c. Plan for the Coming Year

OCCYSHN plans to retire this measure for the coming year. Despite the retirement of this measure, the following activities will continue through FY 2011:

OCCYSHN will continue to train community partners about coverage through efforts of the Oregon Medical Home Initiative. OCCYSHN will also continue its relationship with DMAP relative to identifying issues related to care coordination and challenges of families in rural areas. If available, OCCYSHN will continue to administer Zetosch gift funds to CYSHN families in need of education-related supports.

State Performance Measure 10: *Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		80	80	82	82
Annual Indicator	80.3	80.3	72.4	80.3	80.3
Numerator	6988	6988	7200	6988	6988
Denominator	8706	8706	9945	8706	8706
Data Source				2005/06 NS-CSHCN	2005/06 NS-CSHCN
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	85	85	85	

Notes - 2009
As in 2008, data reported for this State Performance Measure are from the 2005/2006 NS-CSHCN. These are the most current data available for measurement of progress toward this indicator. Please refer to "Notes - 2005" regarding the calculation of the numerator and denominator for this indicator.

Note on data: Of the estimated 8,706 families of CSHCN in Oregon living in rural areas, approximately 80 percent (6,988) indicated that their child had no unmet needs for services.

Data Source: Data used to compute this indicator from the 2005/06 NS-CSHCN. Of the estimated 8,706 respondents living in zip codes identified as non-Metropolitan Statistical Areas (MSAs), 80.3 percent indicated no unmet needs across a range of 15 different health, social and other services.

Notes - 2008
As in 2007, data reported for this State Performance Measure are from the 2005/2006 NS-CSHCN. These are the most current data available for measurement of progress toward this indicator. Please refer to "Notes - 2005" regarding the calculation of the numerator and denominator for this indicator.

Note on data: Of the estimated 8,706 families of CSHCN in Oregon living in rural areas, approximately 80 percent (6,988) indicated that their child had no unmet needs for services.

Data Source: Data used to compute this indicator from the 2005/06 NS-CSHCN. Of the estimated 8,706 respondents living in zip codes identified as non-Metropolitan Statistical Areas (MSAs), 80.3 percent indicated no unmet needs across a range of 15 different health, social and other services.

Notes - 2007
Source: National Survey of Children wtih Special Health Needs, 2005-06.

There are an estimated 116,988 CSHCN in Oregon. 8.5% of CSHCN population in Oregon live in small town/rural areas. 116,988 x .085 = 9945 CSHCN living in small town/rural areas of OR. 27.6% of CSHCN in OR had 1 or more unmet needs for health care services. (9945 x .276 = about 2745 CSHCN with unmet needs living in small town/rural areas of OR.) 9945 – 2745 = 7200 CSHCN with no unmet needs living in small town/rural areas of OR or 72.4%. This number is very similar to OCCYSHN reported in 2006 BUT it may not represent an improvement since

there were more CSHCN living in small town/rural areas of OR (9945 vs. 8706) AND the level of unmet needs increased as well (27.6% vs. 19.7%). These shifts appear to result in a net increase in the number of CSHCN with unmet needs living in small town/rural areas of OR, but this may be in within the range of sampling error, something we will aim to examine this next program year.

a. Last Year's Accomplishments
The Western States Genetic Services Collaborative analyzed cost and satisfaction data to evaluate the viability of telemedicine as a method of offering genetic and other specialty services.

OCCYSHN partnered with family groups and agencies to educate policy makers about needs of families, including increasing access to Medical Homes and the need for comprehensive insurance coverage for CYSHN. OCCYSHN continued efforts to enhance mental health services across the state through work with the Health Matters Subcommittee of the Early Childhood Council. OHSU psychiatrists and AMH also worked with OCCYSHN to explore opportunities to enhance mental services in rural areas. Collaborations with OFH, OFSN and the Oregon Family to Family Health Education and Information Center were continued in attempts to increase family leadership and networking across Oregon.

OCCYSHN utilized community engagement and public health needs assessment methods to identify needs and improve services in rural communities. OCCYSHN utilized phone, email, videoconference, and webinar to sustain connections with rural families and providers given increased travel costs and reductions in overall funding.
OCCYSHN sustained effort with Screening Learning Collaborative teams through policy updates, information dissemination, and ongoing needs assessment activities. PHNs at local health departments were also trained by OCCYSHN nurse consultants on CYSHN-related topics such as developmental screening and surveillance. Through the efforts of the Oregon ABCD Early childhood Screening Initiative, OCCYSHN collaborated with OFH and ODE to spread the use of developmental screening and access to follow-up services across Oregon.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue and enhance OCCYSHN's community based activities, including CaCoon and CCN programs	X	X	X	X
2. Improve developmental screening policies, practices, and follow-up services (ABCD Learning Academy & OCCYSHN's Screening Learning Collaborative)				X
3. Provide focused training to providers throughout the state to increase capacity to provide care to CYSHN				X
4. Collaborate with CDRC providers to link services and information with providers in rural communities				X
5. Partner with other state agencies and organizations to advocate for policy changes that will benefit CYSHN and increase provider capacity to serve CYSHN				X
6. Pilot and promote alternative methods of training, information sharing, and service delivery (telemedicine)				X
7.				
8.				
9.				
10.				

b. Current Activities
OCCYSHN continues to assist families in accessing primary and specialty care through its community based programs, CaCoon and CCN. CaCoon and CCN consultants continue to update and disseminate information on primary and specialty care throughout the state, especially rural areas, to assure knowledge of these services. In spring of this year, CaCoon consultants successfully advocated for expansion of payments for TCM to cover school age children and youth through age 20. CaCoon is also collaborating with OFH to maximize services for CYSHN including exploring opportunities to meet the needs of CYSHN through partnerships with School Based Health Centers.

OCCYSHN continues to collaborate with Health Matters, a health care delivery project, to provide coordinated health care to CYSHN residing in rural Deschutes and Jefferson County.

OCCYSHN is exploring opportunities to engage/partner with rural health care collaborators through medical consultation and other linkages. OCCYSHN is also participating in health care delivery pilot projects including those in rural areas through dissemination of promising practices used in providing coordinated health care to CYSHN. OCCYSHN is also engaging partners and community providers to provide training and education on autism screening and treatment services throughout the state, including rural areas.

c. Plan for the Coming Year
This measure was developed at a time when OCCYSHN received additional federal funding through integrated services grants. With the ending of those funds, OCCYSHN has planned to retire this measure for the coming year. Despite the retirement of this measure, the following activities will continue through FY 2011:

OCCYSHN will partner with groups/agencies to educate policy makers about needs for family support services. Data from the Title V Needs Assessment will also assist OCCYSHN in identifying gaps and advocate for improve services in rural communities. Data specific to rural communities will be analyzed and disseminated early next year.

OCCYSHN will utilize phone, email, videoconference, and webinar to sustain connections with rural families and providers given increased travel costs and reductions in overall funding. Through partnerships with CDRC specialty clinics, OCCYSHN will also continue to provide medical consultation to rural health care providers.

CaCoon nurse consultants will educate key partners regarding the expansion of payments for TCM to cover school age children and youth. OCCYSHN will continue to collaborate with OFH to maximize services for CYSHN including exploring opportunities to meet the needs of CYSHN through CaCoon partnerships with School Based Health Centers.

E. Health Status Indicators
Introduction
Demographic information and data from vital statistics, including poverty levels, describe the Oregon population at large and reflects changes in the proportion of population subgroups. The information allows the Title V programs to identify those areas that need assessment or further analysis. Population changes drive the ability of the Title V programs to serve a specific population with health disparities or inequities. In Oregon, the major population changes continue to be among the Hispanic population, including those who are citizens or are undocumented. The service requirements for this population group require specific cultural competencies among

providers and access to care not covered by Medicaid. More information about Oregon's demographic changes are described in the narrative in "Agency Overview" Section III.A. Data for Health Status Indicators can be found in Form 20, in the Forms section of the Block Grant.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.1	6.1	6.1	6.0	6.2
Numerator	2808	2971	3009	2899	2881
Denominator	45905	48676	49223	48190	46324
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Oregon Center for Health Statistics, 2009.

Notes - 2008
Oregon Center for Health Statistics, 2008.

Notes - 2007
Source: Oregon Center for Health Statistics

Narrative:
Data on birth weight is routinely available from the Oregon Center for Health Statistics.

Low birth weight in Oregon was 5.4-5.5% in 1995-1999. Thereafter, there was an increase to 5.6-5.8 in 2000-2002. Most recent, Oregon low birth weight has been 6.1-6.2% since 2003.

It is likely that the main reason for the increase in LBW since 1999 has been changes in obstetrical care. These changes include increased cesarean deliveries (especially elective cesarean deliveries) and decreased vaginal births after cesarean deliveries (VBAC). Of particular concern is elective cesarean deliveries of women whose expected data of confinement turns out to be incorrect. Obstetricians are just now beginning to understand that operative delivery of infants whose gestational age is 34-36 weeks leads to increased low birth weight and increased negative sequelae for the infant.

See discussion of smoking cessation counseling as a way to decrease low birth weight (below, HSI #1B)

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Indicator	4.7	4.7	4.7	4.5	4.6
Numerator	2085	2198	2232	2115	2071
Denominator	44554	47176	47692	46712	44821
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Oregon Center for Health Statistics, 2009.

Notes - 2008
Oregon Center for Health Statistics, 2008; denominator excludes multiple births.

Notes - 2007
Source: Oregon Center for Health Statistics

Narrative:
Data on birth weight is routinely available from the Oregon Center for Health Statistics.

Low birth weight for singleton births in Oregon has been steady at about 4.6-4.7% since 2005.

A preventable reason for the low birth weight proportion is elective cesarean deliveries. Another way in which low birth weight could be decreased is in decreasing third trimester smoking among pregnant women. Oregon had an active program to teach prenatal care providers to use The 5 A's; the lessons from that program have been incorporated into work that is now done by local health departments. Additional funding for smoking cessation (including advertising, increased access to the Oregon Quit Line and increased education of prenatal care providers in the use of The 5 A's) could further decrease maternal smoking and therefore low birth weight. Oregon PRAMS has asked about several components of The 5 A's. Analysis of that data on prenatal care providers doing optimal smoking cessation counseling led to the discovery that many prenatal care providers are not providing optimal smoking cessation counseling. The work was published in the American Journal of Public Health (Racial/Ethnic Disparities in the Receipt of Smoking Cessation Interventions During Prenatal Care. Tran ST, Rosenberg KD, Carlson NE. Maternal and Child Health Journal, 2009)

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.0	1.0	1.0	1.0	1.0
Numerator	477	508	479	487	472
Denominator	45901	48676	49210	48190	46324
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Oregon Center for Health Statistics, 2009.

Notes - 2008
Oregon Center for Health Statistics, 2008.

Notes - 2007
Oregon Center for Health Statistics, 2007

Narrative:
Data on birth weight is routinely available from the Oregon Center for Health Statistics.

Very low birth weight in Oregon has been steady at 1.0% since 2005.
Oregon has no programs in place to decrease very low birth weight.

It is possible that dramatic improvements in preconception (and especially preadolescent) health could decrease the proportion of very low birth weight and very preterm births.

Some modifiable risk factors for adverse pregnancy outcomes such as preterm birth and low birth weight are obesity, sedentary behavior, and infections. (Downs DS, et al. Design of the Central Pennsylvania Women's Health Study (CePAWHS) strong healthy women intervention: improving preconceptional health. Matern Child Health J. 2009 Jan;13(1):18-28. Epub 2008 Feb 13.)

Prepregnancy nutrition may be an important factor in determining birth weight. For example, in World War II, women were exposed to similar famines in the Netherlands ("the Dutch famine") and Leningrad ("the siege of Leningrad"). Birth weights of both groups of women decreased during the famines but the birth weights of the Dutch women decreased more because they had better nutrition before the famine. (Thomson AH. Technique and perspective in clinical and dietary studies of human pregnancy. Proc Nutr Soc. 1957;16:45-51.)

The Oregon Office of Family Health is developing a collaborative project with local health departments to promote better preconception health.

OFH continues to talk with Dr. David Barker (at the Oregon Health & Sciences University) about the impact of events before and early in pregnancy on a variety of outcomes, including adult cardiovascular disease.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.8	0.8	0.8	0.8	0.7
Numerator	353	366	361	365	328
Denominator	44554	47176	47680	46712	44821
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Oregon Center for Health Statistics,2009.

Notes - 2008
Oregon Center for Health Statistics, 2008; denominator excludes multiple births.

Notes - 2007
Source: Oregon Center for Health Statistics

Narrative:
Very low birthweight for singleton births in Oregon has been steady at 0.7-0.8% since 2005. Oregon has no programs in place to decrease very low birthweight.

See HSI 2A for more information

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.1	8.5	6.2	6.2	6.2
Numerator	43	60	45	45	45
Denominator	699202	702864	724681	724681	724681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 and 2009 data are not available, carried forward 2007 data.

Sources: Numerator: CDC-WISQARS; Denominator: 2007 Oregon Annual Population Report (PSU) for 0-14 yrs old.

For HSI #3A-3C: For future reportings, age-specific injury data will be obtained directly from the Injury program to get more complete data.

Notes - 2008
2006 data pulled from WISQARS on 4/30/09. More recent data is not available.

Notes - 2007
2006 data from CDC Web-based Injury Statistics Query and Reporting System. More recent data is not available.

Narrative:

The top causes of unintentional injury death to children aged 14 years and younger are 1) motor vehicle
crashes/occupants 2) drowning 3) suffocation, 4) motor vehicle crashes/pedestrians, and 5) fire/flame. We encourage local health departments to screen families for child safety seat needs and send them to local coalition members that can provide the seat with education on installation and use. Additionally, we were instrumental in passing Oregon's booster seat law that requires children to remain in a booster seat until age 8 or 4'9", which passed in 2007. We provide mini-grants to local coalitions to erect Lifejacket Loaner Kiosks at rivers and lakes in order to promote the use of lifejackets while swimming in rivers and lakes. We also distribute Water Watcher cards to parents to understand that they need constant supervision with children while in any body of water, even bathtubs. We also provide mini-grants to local coalitions to support walking and bicycling to school and teaching pedestrian safety. We participated in the development of Safe Sleep guidelines and distribute those to coalitions. We partner with the fire service to promote smoke detector use.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.0	3.3	1.4	1.4	1.4
Numerator	21	23	10	10	10
Denominator	699202	702864	724681	724681	724681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Sources: Numerator: CDC-WISQARS; Denominator: 2007 Oregon Annual Population Report (PSU) for 0-14 yrs old. 2008 and 2009 data are not available, carried forward 2007 data.

Notes - 2008
2006 data pulled from WISQARS on 4/29/09.

Notes - 2007
2006 data from CDC Web-based Injury Statistics Query and Reporting System.

Narrative:
We encourage local health departments to screen families for child safety seat needs and send them to local coalition members that can provide the seat with education on installation and use. Additionally, we were instrumental in passing Oregon's booster seat law that requires children to remain in a booster seat until age 8 or 4'9", which passed in 2007.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	23.7	23.8	21.4	21.4	21.4
Numerator	113	116	111	111	111
Denominator	476089	487935	518599	518599	518599
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Sources: Numerator: CDC-WISQARS; Denominator: 2007 Oregon Annual Population Report (PSU) for 0-14 yrs old. 2008 and 2009 data are not available, carried forward 2007 data.

Notes - 2008
2006 data from CDC Web-based Injury Statistics Query and Reporting System. More recent data is not available.

Notes - 2007
2006 data from CDC Web-based Injury Statistics Query and Reporting System. More recent data is not available.

Narrative:
We participate as Advisory Committee members to the Youth Program and Occupant Protection Programs with Oregon Department of Transportation. We partner in their media campaigns and have a task force looking at media messages to non-English-speaking residents. We also provided testimony in favor of Oregon's hands-free /no texting on a phone while driving law.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	230.3	174.0	160.6	160.6	160.6
Numerator	1610	1222	1164	1164	1164
Denominator	699202	702322	724681	724681	724681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Source: Injury and Violence Prevention Program. 2007 data is part of the upcoming 2010 Injury in Oregon Annual Report. 2008 and 2009 are not available, 2007 data carried forward.

Notes - 2008
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Notes - 2007
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Narrative:
The leading cause on nonfatal injuries to children aged 14 years and younger is falls. Leading causes of falls include those that occur: on playgrounds, in the home (stairs, chairs, beds), out of buildings, scooters/skateboards/skiing, and one level to another. Safe Kids is holding a public Window Falls Summit Nov. 9 to encourage community discussion on how best to promote window safety. We partner with home visiting nurses to identify home fall hazards, and encourage helmet use while in wheeled or snow sports.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.5	20.2	17.9	17.9	17.9
Numerator	171	142	130	130	130
Denominator	699202	702191	724681	724681	724681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Same data source as HSI #4A.

Notes - 2008
Source: Hospital Discharge Data, 2006. Data for 2007-2008 not available.

Notes - 2007
Source: Hospital Discharge Data, 2006. Data for 2007-2008 not available.

Narrative:
We encourage local health departments to screen families for child safety seat needs and send them to local coalition members that can provide the seat with education on installation and use. Additionally, we were instrumental in passing Oregon's booster seat law that requires children to remain in a booster seat until age 8 or 4'9", which passed in 2007.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	141.4	111.3	111.3	111.3	105.7
Numerator	673	550	550	550	548
Denominator	476089	494160	494160	494160	518599
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Same data soruce as for HSI #4A and HSI #4B, where estimate for denominator is for 15-24 years of age.

Notes - 2008
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Notes - 2007
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Narrative:
We participate as Advisory Committee members to the Youth Program and Occupant Protection Programs with Oregon Department of Transportation. We partner in their media campaigns and have a task force looking at media messages to non-English-speaking residents. We also provided testimony in favor of Oregon's hands-free /no texting on a phone while driving law.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	18.0	18.0	20.1	21.4	24.3
Numerator	2202	2202	2516	2672	3041
Denominator	122333	122333	125165	125090	125090
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Sources: Numerator from Office of Disease Prevention and Epidemiology (ODPE); Denominator: population estimates for female 15-19 years of age from 2009 Annual Oregon Population Report.

Notes - 2008
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 15-19 comes from Portland State Population Center Annual Population Report (2008), table 9.

Notes - 2007
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 15-19 comes from Portland State Population Center Annual Population Report (2008), table 9.

Narrative:
Since 1987, Oregon has had a rule that all providers and laboratories must report all confirmed cases of cases of clamydia to their local health department. The local health departments report these cases to the state health department, which keeps the reports in the Sexually Transmitted Disease Management Information System (STDMIS).

The data is organized to count more than one case of clamydia in a year but multiple reports on the same case of chlamydia are deduplicated.

Starting in March 2010, the STDMIS data will move to a new database, known as ORPHEUS (Oregon Public Health Epidemiology User System). It is hoped that changing to the new database will not affect the reliability of the data for assessment of trends over time.

From 2005-2009, there was a significant increase in cases of chlamydia among women 15-19 years old -- from 18.0% to 24.3%. We believe that there are two reasons for this increase: more sensitive lab methods and increased screening.

LAB METHODS: Oregon labs have recently moved to using nucleic acid amplification testing, which is more sensitive than previous technologies.

INCREASED SCREENING: It is likely that more women are being screened each year for chlamydia in Oregon. There is increasing interest among HMOs and other provider groups in the HEDIS measure for chlamydia screening among women age 15-25 years old. This would motivate systems and providers to screen more women more often (every year) than in previous years.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.9	6.3	7.0	7.4	7.8
Numerator	3874	3874	4355	4665	4925
Denominator	656610	610656	622223	633145	633415
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Sources: Numerator from Office of Disease Prevention and Epidemiology (ODPE); Denominator: population estimates for female 20-24 years of age from 2009 Annual Oregon Population Report.

Notes - 2008
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 20-44 comes from Portland State Population Center Annual Population Report (2008), table 9.

Notes - 2007
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 20-44 comes from Portland State Population Center Annual Population Report (2008), table 9.

Narrative:
THE FOLLOWING IS IDENTICAL TO NARRATIVE IN #5A:

Since 1987, Oregon has had a rule that all providers and laboratories must report all confirmed cases of cases of clamydia to their local health department. The local health departments report these cases to the state health department, which keeps the reports in the Sexually Transmitted Disease Management Information System (STDMIS).

The data is organized to count more than one case of clamydia in a year but multiple reports on the same case of chlamydia are deduplicated.

Starting in March 2010, the STDMIS data will move to a new database, known as ORPHEUS (Oregon Public Health Epidemiology User System). It is hoped that changing to the new database will not affect the reliability of the data for assessment of trends over time.

From 2005-2009, there was a significant increase in cases of chlamydia among women 15-19 years old -- from 18.0% to 24.3%. We believe that there are two reasons for this increase: more sensitive lab methods and increased screening.

LAB METHODS: Oregon labs have recently moved to using nucleic acid amplification testing, which is more sensitive than previous technologies.

INCREASED SCREENING: It is likely that more women are being screened each year for chlamydia in Oregon. There is increasing interest among HMOs and other provider groups in the HEDIS measure for chlamydia screening among women age 15-25 years old. This would motivate systems and providers to screen more women more often (every year) than in previous years.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	49701	41514	1416	1139	2190	235	3207	0
Children 1 through 4	198208	168978	5905	4294	8032	809	10190	0
Children 5 through 9	239157	204324	7162	5003	9973	929	11766	0
Children 10 through 14	237176	205076	7007	4059	9062	801	11171	0
Children 15 through 19	251785	219979	6665	4612	9309	981	10239	0
Children 20 through 24	261149	229024	6190	5383	10489	957	9106	0
Children 0 through 24	1237176	1068895	34345	24490	49055	4712	55679	0

Notes - 2011
Source: Population estimates for all age groups in each race for HSI #6A and HSI #6B from U.S. Census, 2009 Population Estimates data by 6-race categories and age available online at: http://www.census.gov/popest/states/asrh/

Narrative:
The total estimated population of infants and children aged 0 through 24 years in Oregon during 2009 was 1,237,176; this accounts for 32% of the total Oregon population (3,823,465). Within this population age group, 86.4% were White, 2.8% were Black, 2.0% were American Indian/Native Alaskan, 4.0% were Asian, 0.4% were Hawaiian or Pacific Islander, 17.9% were Hispanic/Latino and 82.1% were non-Hispanic/Latino. Overall, the largest youth groups were White and Hispanic/Latino.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	38699	11002	0
Children 1 through 4	152354	45854	0
Children 5 through 9	187920	51237	0
Children 10 through 14	195164	42012	0
Children 15 through 19	214396	37389	0
Children 20 through 24	226858	34291	0
Children 0 through 24	1015391	221785	0

Notes - 2011

Narrative:
Interpretation integrated in HSI #6A

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	39	26	0	3	1	0	2	7
Women 15 through 17	1150	861	34	44	12	4	79	116
Women 18 through 19	2845	2288	93	71	25	14	132	222
Women 20 through 34	35594	29428	736	488	1553	266	1214	1909
Women 35 or older	6696	5474	121	60	546	24	140	331
Women of all ages	46324	38077	984	666	2137	308	1567	2585

Notes - 2011
Source: Oregon Center for Health Statistics, provisional 2009

Narrative:
The overall racial makeup in Oregon shows a shift toward increasing racial diversity. For example, as noted in HSI #6A and #6B, 86.4% of children 0-24 are White. Similarly 82.2% of births in 2009 were to White mothers. On the other hand, there is a trend towards an increasing percent of Hispanic children. In 2009, Hispanics comprise 17.9% of all children 0-24, and they comprise 25.9% of infants 0-1.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	15	24	0
Women 15 through 17	644	503	3
Women 18 through 19	1995	839	11
Women 20 through 34	28509	6988	97
Women 35 or older	5527	1139	30

Women of all ages	36690	9493	141

Notes - 2011

Narrative:
Interpretation integrated in HSI #7A

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	241	208	4	5	5	2	10	7
Children 1 through 4	41	28	1	2	1	1	2	6
Children 5 through 9	28	24	0	1	0	0	1	2
Children 10 through 14	35	25	3	2	1	2	2	0
Children 15 through 19	109	89	1	3	3	1	6	6
Children 20 through 24	198	171	5	7	5	2	3	5
Children 0 through 24	652	545	14	20	15	8	24	26

Notes - 2011
Source: Oregon Center for Health Statistics, provisional 2009

Narrative:
In 2009, white children accounted for 83.6% of deaths to children age 0-24, Blacks 2.1%, American Indians 3.1%, Asians 2.3% and Hawaiian/Pacific Islanders 1.2%. Those with more than one race accounted for 3.7% of deaths and others/unknown for 4.0%. Comparisons to the overall racial composition of 0-24 year olds is not possible because the most recent population data only includes the Hawaiian/Pacific Islander, more than one race, and other/unknown categories for 0-1 year olds whereas the death data includes those categories for the full 0-24 age group. Latino/Hispanic children comprised 17.9% of deaths to children age 0-24.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	190	50	1

Children 1 through 4	31	10	0
Children 5 through 9	21	7	0
Children 10 through 14	30	5	0
Children 15 through 19	82	27	0
Children 20 through 24	180	18	0
Children 0 through 24	534	117	1

Notes - 2011

Narrative:
Interpretation integrated in HSI #8A

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	976027	839871	28155	19107	38566	3755	46573	0	2009
Percent in household headed by single parent	29.0	28.2	53.2	42.1	15.6	50.7	31.0	30.5	2008
Percent in TANF (Grant) families	5.9	5.5	25.3	10.0	3.1	13.7	3.2	0.0	2009
Number enrolled in Medicaid	207285	157933	13107	5983	7566	0	0	22696	2009
Number enrolled in SCHIP		0	0	0	0	0	0	0	2009
Number living in foster home care	13434	8592	106	195	35	40	2895	1571	2009
Number enrolled in food stamp program	359805	243805	16894	7285	7113	2056	3820	78832	2009
Number enrolled in WIC	111566	82377	2769	15300	1947	793	8380	0	2008
Rate (per 100,000) of juvenile crime arrests	903.7	854.6	3327.7	656.9	394.8	0.0	0.0	0.0	2008
Percentage of high	3.4	2.9	6.1	6.4	2.4	0.0	2.8	5.7	2009

school drop-outs (grade 9 through 12)									

Notes - 2011
All children 0 through 19: Same source as HSI #06A, data for 0-19 carried over. Of the total children less than 25 years old in 2009, 78.9% (n=976,027) were 0-19 years of age.

Percent in household headed by single parent:
Data derived from 2008 American Community Survey (ACS) for children 0-17 years of age in single headed household, available at http://factfinder.census.gov/home/saff/main.html?_lang=en. Numerator: Total children in male-only and female-only ihousehold in each race/ethnicity. Denominator: Total children in each race/ethnicity. Children defined as 0-17 in both NSCH and ACS.

Percent in TANF (Grant) families:
Data from Children, Adults and Families (CAF) Division, Self-Sufficiency office, based on "counts of TANF Clients." Denominator: U. S. Census, 2009 Population estimates reported for "All children 0-19." TANF's data is by individual person and not family.

Number enrolled in Medicaid:
Data from DMAP for ages 0-18, based on calender year. Unduplicated clients count from cumulative monthly demographic reports by race/ethnicity and age for 2009. OHP application does not collect information for >= 2 races, and for "Other and Unknown." Asian and Hawaiian/PI are lumped as one group. Other and unknown may include Hispanics. Medicaid/OHP enrollment data by race/ethnicity includes SCHIP as it is a portion of the Plus package, so enrollment by race cannot be broken down by SCHIP.

Number enrolled in food stamp program:
Data from Children, Adults and Families Division (CAF)/Self Sufficiency, based on counts of person on food stamp program.

Number enrolled in WIC:
Data from WIC program for chidlren 0-5 years of age. Final 2008 data, 2009 data is not available.

Rate (per 100,000) of juvenile crime arrests:
Final 2008 data from Oregon Uniform Crime Reporting for juvenile defined as 0-17 years of age. Numerator: Index Total for juvenile arrests in each race/ethnicity. Data by age and race/ethnic categories available for only "White, Black, Indian, Hispanic," and Asian (refers to as "Indochinese" and "Other Asian"). Denominator: US Census, 2008 population estimates for ages 0-17 in each race/ethnicity categories.
Comparison should not be made with data reported in 2005 and prior years due to differences in computation method. There is no program log if 2005 and prior data were based on total all arrests or Index total, or how denominator was defined. JV arrest data has not been reported since 2005, so 2008 data will serve as baseline data.

Percentage of high school drop-outs (grade 9 through 12):
Data from Oregon Department of Education for school year 2008-09. Except for "Not Hispanic or Latino" data available at: http://www.ode.state.or.us/search/page/?id=1.

Number living in foster home care:
Data from Child Welfare program based on FFY 2009, and refers to living in any Foster Care Arrangement.

Narrative:
Items of note from the miscellaneous demographic data include the following:

In 2008 (the most recent year for which data is available), Blacks (53.2%) were much more likely to be living in a household headed by a single parent than Whites (28.2%). This was similar in 2004 -- where Blacks were more likely to be living in single heahed household than Whites. Both the NSCH and ACS identify children as 0-17 years of age.

Similarly, in 2009, Blacks were much more likely to receive TANF (25.3%) than other racial/ethnic groups (second highest was Hawiian/Pacific Islander: 13.7%, followed by Hispanics: 11.4%). There seems to be a decrease in percentage of children aged 0-19 on TANF between 2007 (6.7%) to 2009 (5.9%); however, such comparison should be with caution due to different methods in reporting TANF data.

In 2009, about 207,285 children aged 0-18 were on Medicaid/Oregon Health Plan. A total of 1,104,347 children were in Oregon during 2009 (2009 Oregon Annual Population Report). This indicates that 27.0% of children received Medicaid that year. Hispanics/Latino (50.6%) and Black/African American (48.8%) children were the highest group on OHP followed by American Indian/Alaskan Native (33.1%), White (19.9%), Asian/Pacific Islander (18.9%), and other/unknown (51.0%). However, these estimates should be interpreted with caution because of the number of children with un-identifiable race/ethnicity; these children could belong in any of the 5 racial groups making the numbers for the 5 groups unstable (i.e.: White, Black, American Indian, Asian, and Hawaiian/Pacific Islander).

In 2009, children with 2 or more races (6.2%, n = 2,895) were more likely to be living in foster care than any other children from other races or ethnicity.

Similarly to TANF, Blacks were more likely to be recipients of food stamp (60.0%, n=16,894) than any other groups. Next highest were Hawaiian or Pacific Islander (54.8%, n=2,056) and Hispanics or Latino (45.9%, n=86,132). Overall, in 2009, about 37% of children 0-19 years of age were on the Food Stamp program.

In 2008 (the most currently available data), 111.566 children received WIC services. Based on the 2008 American Community Survey, there were 283,771 children aged 0-5 years old. This shows that 37.8% children received WIC services.

In 2008 (the most recent year for which data is available), the juvenile crime rate among Blacks was substantially higher than that of other racial/ethnic groups. The rate among Asians and Hispanics were substantially lower than the state average (873.4/10,000).

In the 2008-2009 school year, several groups (Blacks, American Indian/Alaskan Natives and Hispanics) had dropout rates that were substantially higher than the state average.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	788533	187494	0	2009
Percent in household headed	27.2	34.6	0.0	2008

by single parent				
Percent in TANF (Grant) families	6.8	11.4	0.0	2009
Number enrolled in Medicaid	0	91315	0	2009
Number enrolled in SCHIP	0	0	0	2009
Number living in foster home care	11161	1706	567	2009
Number enrolled in food stamp program	251829	86132	21844	2009
Number enrolled in WIC	65101	45549	916	2008
Rate (per 100,000) of juvenile crime arrests	0.0	723.3	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.1	5.1	0.0	2009

Notes - 2011

Narrative:
Interpretation integrated in HSI #09B

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	839383
Living in urban areas	784178
Living in rural areas	180334
Living in frontier areas	24212
Total - all children 0 through 19	988724

Notes - 2011
Sources: U.S. Census, Office of Rural Health, and Oregon Population Research Ctr (PSU). Data for urban/rural/metropoliatn areas from 2008 ACS, available at http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=datasets_2&_lang=en.
Frontier areas obtained from 2008 Annual Oregon Population Report (PSU) based on definition for frontier provided by Office of Rural Health (OHSU) (http://www.ohsu.edu/ohsuedu/outreach/oregonruralhealth/data/publications/maps.cfm). Year 2008 data is reported here (and not 2009 data) to be consistent with data year (i.e. 2008) for rural/urban areas.

Narrative:
The vast majority of children in Oregon (85.0%) lived in metropolitan areas. The rest (15.0 %) lived in
non-metro areas. Most Oregon children (79.4%) lived in urban areas, with the rest living in rural (18.3%) or frontier (2.5%) areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3791060.0
Percent Below: 50% of poverty	4.6
100% of poverty	10.6
200% of poverty	32.5

Notes - 2011
Source for total population is 2008 Annual Oregon Populaton Report (PSU).

Soruce for poverty data is 2009 Current Population Survey (APS), available at: www.census.gov/hhes/www/cpstc/apm/cpstc_altpov.html.

Narrative:
Under 5% of the overall Oregon population is below 50% of poverty (4.6%).
However, for children, this percentage is much higher (5.6%). Similarly, children are more likely to be below 100% and below 200% of poverty than the general population.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	987029.0
Percent Below: 50% of poverty	5.6
100% of poverty	14.4
200% of poverty	42.4

Notes - 2011

Narrative:
Interpretation integrated in HSI #11

F. Other Program Activities

MCH Toll-Free Line: 1-800-SafeNet is Oregon's statewide MCH Information and referral line. It was established in April 1991, and is funded jointly by Title V, Title X, WIC, and Immunization and Oregon Food Stamps Programs. SafeNet's information and referral services are provided through a contract with the agency 211Info and the Office of Family Health. 211info owns the 211 National Social Service number for the state of Oregon, however they are not yet statewide. The website for 211info and SafeNet is http://www.oregonsafenet.org/

The 211info and SafeNet call lines link low income Oregon residents with health care services in their communities; assist in identifying and prioritizing needs of callers with immediate, multiple health care concerns; match provider callers with appropriate information concerning options; track and document service gaps. Outreach for SafeNet occurs through Medicaid card messages

and inserts (WIC, prenatal, flu, and dental), state public health and social services brochures, community networking and presentations, websites, DHS offices, local health departments, private providers, managed care plans and social service agencies. Special advertising campaigns designed to move particular target audiences to call SafeNet for particular time-sensitive information is conducted periodically. SafeNet is utilized as a part of other nutrition and food assistance programs such as in Food Stamp Outreach and Summer Food site information. At present eleven staff members are fully trained in taking Oregon SafeNet calls.

A Prenatal and Newborn Resource Guide for Oregon Families is a book was designed and disseminated to hospitals and birthing centers to distribute to new mothers, and included content specific to health and care of newborns and early childhood. The guide is available on http://www.oregon.gov/DHS/ph/ch/newborn_resource_guide.shtml

Program Evaluations
"First Tooth" Project Evaluation: The HRSA-funded "First Tooth" Project will train medical pediatric providers to do oral health screenings and apply fluoride varnish for children ages 0-3, and train general dentists to provide dental services to children 0-3. The project evaluation is currently collecting data on the Phase I pilot training sites. Data that are collected in this phase will be used to modify and adapt training materials for Phase II - statewide implementation. Evaluation activities will be conducted throughout the 3-year project to assess and refine implementation and to assess outcomes of the entire project.

Project LAUNCH Evaluation: LAUNCH is a 5-year SAMSHA grant addressing early childhood mental health. The evaluation is designed to assess the efforts of building a local/state-coordinated, comprehensive early childhood system in Deschutes County and the state. The evaluation uses a variety of methods including client/service data analysis, surveys/interviews/focus groups of parents, service providers and community members, and a trend analysis of community-wide child wellness indicators. Data is compiled and reported on a quarterly, semiannually and yearly basis.

Early Hearing Detection and Intervention (EHDI) Evaluation: The EHDI program evaluation tracks data for each stage of the hearing screening system (i.e., hospital or outpatient screening, audiological evaluation for referred infants, and Early Intervention for infants diagnosed with hearing loss). Evaluation staff tracks the percentage of infants that are not screened and the percentage of infants that do not complete recommended assessments and/or EI enrollment. These data, which are monitored at both the county and state level, are used to strengthen screening and follow-up procedures.

Early Childhood Comprehensive Systems (ECCS) Evaluation: The ECCS project's evaluation has three areas of emphasis: developing and tracking process measures that accurately assess the work of each of the three project committees; collaborating with the committees and the project's data team to develop a set of approximately 35 ‘leading indicators' that will measure the overall status of early childhood in Oregon, and working with the data team to determine the feasibility and steps involved in creating a unified early childhood data system across agencies.

Community Connections Network (CCN) Annual Evaluation: An end of year survey is administered annually using SurveyMonkey. CCN Team members and community professionals who participated in CCN over the last year are surveyed. The survey captures the perceptions of professionals on the impact of the CCN program (on children and youth, families, communities and professionals' work). For quality improvement purposes, it also evaluates team processes and helpfulness of CCN-related tools and activities.

CaCoon Program Evaluation: CaCoon program data is analyzed and summarized into an annual evaluation report that addresses the strengths and opportunities for improvement in the implementation of CaCoon and obtained outcomes. The Oregon Child Health Information Data System (ORCHIDS) data is assessed quarterly for multiple purposes including billing practice

assessments, program evaluation, and Title V reporting and to identify areas for quality improvement.

OCCYSHN Training Evaluation Summary: OCCYSHN invests considerable resources into the training of providers and families around meeting the needs of CYSHN. Training evaluation surveys accompany every training event. The data are reviewed both in real time and in summary at the end of the program year to determine opportunity for improvement in training methodology and in the identified, as yet, unmet training needs of the target audience. The evaluation provides feedback on the effectiveness and impact (moving to practice) of training.

Community Engagement events provide a forum for families, health care providers and other service providers to provide input on what was needed to most appropriately support CYSHN in the community. The community engagement activity results in a formal Community Assessment report as well as set the framework for a community engagement model that could be replicated in other communities across the state.

G. Technical Assistance

Oregon's Title V technical assistance requests are to support agency and program efforts to address 2010 and ongoing needs assessment, strategic planning, and workforce development and competencies.

A). Implementation of Five-Year Needs Assessment
Youth Health Summit
Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) is planning a statewide summit addressing the needs of youth/young adults in their successful transition to adult healthcare, living independently and work/education. Desired outcomes actionable plans focused on priorities emanating from the state level summit to work toward improved systems of care and access for youth/young adults with special health needs.
Purpose: Develop an agenda and strategies for funding and bringing together individuals and groups with widely varying agendas to create and commit to an action plan toward improved services to youth/young adults with special health needs, to be implemented by OCCYSHN
Supports: General Systems Capacity
Proposed T.A.: Group Facilitator with experience in special health needs issues and leading diverse group processes, goal setting and planning.

Strategic planning
Following the priority setting from the Title V Needs Assessment, strategic planning activities with stakeholders and partners will be needed to guide work on several measures over the next few years.
Purpose: To identify development of policies, programs, partnerships and any specific interventions or additional assessment needed, for each of the new priority areas.
Supports: General System Capacity
Proposed T.A.: Strategic planning facilitator with experience in leading diverse group processes, goal setting and planning

Child Health Collaborative
State and Local MCH Public Health Nursing leadership met in 2010 to identify priority areas for shared planning and implementation. The group identified Oral Health Prevention, Obesity Prevention, and Unintended Injury Prevention as the leading issues. The group will develop action plans and will return for another retreat in late 2010 to affirm and commit to activities to implement these issues.

Purpose: Facilitate priority setting and planning for child health priorities
Supports: General Systems Capacity
Proposed T.A.: Facilitator with expertise in MCH Public Health and Public Health Nursing for a two-day retreat

B). Assessment and Surveillance
Asset Mapping and Dissemination of Financial Resources and Insurance Supports for Families
With current economic conditions and significant un/under-insurance issues for families of children with special needs, OCCYSHN would like to take a lead role in 1) obtaining data of recession impacts on families of children with special health needs, and 2) identifying and disseminating resources available to families and providers to assist in meeting coverage and financing needs. Community asset mapping is a strategy to identify needs and resources for families. OCCYSHN would like technical assistance from the Catalyst Center create strategies and activities that will address family financial hardships.
Purpose: A strategic plan for reducing impact of family financial hardships
Supports: National Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need
Proposed T.A.: Catalyst Center

OCCYSHN Comprehensive Evaluation and Assessment Plan
A comprehensive and manageable ongoing plan of program evaluation and assessment is needed to inform and guide OCCYSHN's limited evaluation resources. Increasingly, data about status and services for children with special health needs is needed to adequately and expertly inform public and organizational development of policies, programs and decisions. OCCYSHN needs assistance to plan and create an organizational strategy that will improve capacity for evaluating outcomes of our systems of care efforts at the community-based level, and strategies for funding these activities in an intense budget limiting environment.
Purpose: Increase capacity of OCCYSHN evaluation and assessment capacity
Supports: Data Related Issues: Data systems and needs assessment
Proposed T.A.: TBD

Assessment of disparities
Conduct focus groups of parents, providers and others to determine areas or populations experiencing disparities around each of the priority areas.
Purpose: To assess disparities and needs among sub populations and regions
Supports: Needs assessment for new State Performance Measures
Proposed T.A.: Resources to support community-based research and focus groups

C). Provider Training and Workforce Development
Domestic and Sexual Violence Training
Family violence has been identified as a top priority of the 2010 Title V Needs Assessment. Maternal and Child Health programs need to identify best practices to improve their screening, counseling and referral related to domestic violence, sexual assault, and reproductive coercion.
Purpose: The Oregon Teen Pregnancy Task Force is inviting Dr. Elizabeth Miller to be a keynote speaker at the 2011 Adolescent Sexuality Conference in Seaside, Oregon. The Office of Family Health could maximize her time in Oregon by having her provide training to public health nurses and professionals on how to effectively screen for reproductive coercion, sexual and domestic violence. Sessions could include a presentation during public health week and a one or two day training for public health nurses.
Performance measure: New State Measure 1
Supports: General Systems Capacity
Proposed T.A.: Elizabeth Miller, MD, PhD, Assistant Professor of Pediatrics at University of California at Davis Children's Hospital; Other potential TA trainers include: Dr. Nancy Glass; Lisa

James, Director of the Family Violence Prevention Fund's Project on Health Care and Domestic Violence; Dr. Judith McFarlane, Texas Women's University; Dr. Jacqueline Campbell

Medical Home Training for Physicians and Community Providers
Current efforts around health care reform in Oregon emphasize the need for coordinated primary care but often do not include the comprehensive practice of medical home for children and youth with special needs as identified by MCH, AAP, and others. OCCYSHN believes there is a need to provide consultation and training around Medical Home for physicians and other community providers who provide primary care to CYSHN. Although information is available online, personalized training in Oregon is expected to result in broader implementation of the national model for CYSHN.
Purpose: Trainings for primary care providers that includes principles and strategies for improving the practice of Medical Home.
Supports: Performance Measures: Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home; State Performance Measure 8: Percent of health care providers who report confidence in caring for CYSHN and their families
Proposed T.A.: Dr. Fan Tait, Associate Executive Director of the American Academy of Pediatrics (AAP) and Director of the Department of Community and Specialty Pediatrics at the AAP

Medical Provider Training Modules on Bright Futures Adolescent Well Visit
Oregon OFH and DMAP child health leaders are advocating that Bright Futures well-visit recommendations be adopted as standards for child and adolescent preventive health practice. The child health provider work force, including pediatricians, family physicians, nurse practitioners, and public health nurses, will need to be educated or trained in the standards of the well-visit and adopt clinical protocols.
Purpose: Develop products or modules to train providers on how to meet the Bright Futures recommended content for the Child and Adolescent Well Visit, such as a webinar or an interactive online training module, that qualifies for continuing education and/or quality improvement activities for professional recertification.
Supports: General Systems Capacity
Proposed T.A.: Paula Duncan, MD or her recommendations

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	6206342	6225453	6226453		6225530	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	13163039	28598212	12851225		13202453	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	7268157	6682798	7808723		7788590	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	26637538	41506463	26886401		27216573	
8. Other Federal Funds *(Line10, Form 2)*	112448781	43185915	61077155		62540357	
9. Total *(Line11, Form 2)*	139086319	84692378	87963556		89756930	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1514563	2138266	1374181		1309862	
b. Infants < 1 year old	8805641	15440320	9371270		9359857	
c. Children 1 to 22 years old	10199614	19509483	10129495		10745784	
d. Children with	3372036	3262575	3264363		3262598	

Special Healthcare Needs						
e. Others	1251826	79717	1251826		660877	
f. Administration	1493858	1076102	1495266		1877595	
g. SUBTOTAL	26637538	41506463	26886401		27216573	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	319757		312657		440000	
b. SSDI	94664		94664		94664	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	70001569		18637043		18544041	
h. AIDS	0		0		0	
i. CDC	8424887		8424887		9200881	
j. Education	0		0		0	
k. Other						
FPEP Waiver	31016826		31016826		31016826	
Other Fed Funds	0		289198		1012945	
Title X, Family Plan	0		2301880		2231000	
Others	289198		0		0	
Title X Famly Plan	2301880		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	5205306	7308830	5291517		5778726	
II. Enabling Services	8951554	17493346	9009309		9511350	
III. Population-Based Services	1926149	3680385	1921163		1721976	
IV. Infrastructure Building Services	10554529	13023902	10664412		10204521	
V. Federal-State Title V Block Grant Partnership Total	26637538	41506463	26886401		27216573	

A. Expenditures

Oregon's expenditure and budget report represent the totals from both Title V Agencies -- Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs. The totals include all those funds under the direction of the Title V Director in OFH and OCCYSHN, which include Federal Funds, State General Funds, and Other Funds. Each of these funds are on different cycles which makes for some estimates in some cases. The expenditures are final for a federal fiscal year (October-September) or a state fiscal year (July-June) for the same general time period. Oregon is on a biennial budget so the projection is generally half of the Legislative Approved budget or, in a Legislative year, a pending Governor's budget. Notes about

the sources for the expenditures and budget are included in the Forms.

The Federal/State Partnership expenditures report on Forms 3, 4 and 5 for 2008, include all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs). The 3:4 Title V match includes expenditures or revenues in local health departments that are not used for match for Targeted Case Management and Medicaid Administrative Match, including fees, County General Fund and other Third Party payments. There can be fairly wide variations on Forms 3, 4, and 5 between the budget projection and the expenditures, which follows two years later. Variations are generally caused by differences between the state and county budget amounts and actual expenditures funded by revenue generated by federal payments for eligible services, such as the Family Planning Expansion Project (counting clients under age 21) and Babies First home visiting programs. Other match is calculated from county program expenditures using revenue sources that are non-federal (client fees, county general fund) and that is not used for federal match.

The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies count as Direct and Enabling Services. Funds that are used at the State level, in the Office of Family Health, are distributed between Population-Based and Infrastructure, prorated according the type of activities occurring in the state-level programs.

The Oregon Center for Children with Special Health Needs reports its expenditures into the Federal/State Partnership expenditures report (Forms 3, 4 and 5 for 2009) and includes all of its 30% federal funds transferred from the Office of Family Health to OCCYSHN along with matching state General Funds. OCCYSHN community --based programs (CaCoon, Community Connections) are allocated approximately 30% in Enabling services and the remainder in Infrastructure services.

The Oregon Title V Expenditures are generally based on reports from the Office of Family Health, Oregon Center for Children and Youth with Special Health Needs, and from county health department reports submitted to the Public Health Division. In each annual report, the expenditures are based on actual expenditures at the time of the preparation of the Title V report (around May of each year. The Expenditures for FY 2009 are for the period October 1, 2008 through September 30, 2009.

B. Budget

Oregon's budget and expenditures report represent the totals from both Title V Agencies -- Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs. The totals include all those funds under the direction of the Title V Director in OFH and OCCYSHN, which include Federal Funds, State General Funds, and Other Funds. Each of these funds are on different cycles which makes for some estimates in some cases. The expenditures are final for a federal fiscal year (October-September) or a state fiscal year (July-June) for the same general time period. Oregon is on a biennial budget so the projection is generally half of the Legislative Approved budget or, in a Legislative year, a pending Governor's budget. Notes about the sources for the expenditures and budget are included in the Forms.

The Federal/State Partnership budget includes all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs). The budget does not include anticipated expenditures from revenues generated by match or new grants in the Title V Offices or local health department MCH programs.

The Office of Family Health, Title V Program, meets its 30-30 minimum requirement by

transferring 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children with special health care needs. No administrative or indirect is retained by OFH prior to transfer. The required Maintenance of Effort for Oregon is $3,950,427 and the Title V Offices assure this minimum through funds generated at the state and local levels that benefit the maternal and child health population. The 3:4 Title V match in the budget are projected revenues from state general funds and county local funds, including patient fees, local general funds, and non-Medicaid 3rd-party payments, that are not used for match for other federal programs. The Oregon Legislature appropriates the state funds on a biennial basis and the state appropriates funds for local grants on an annual basis.

The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies count as Direct and Enabling Services. Funds that are used at the State level, in OFH are distributed between Population-Based and Infrastructure prorated according the type of activities occurring in the state-level programs.

The OCCYSHN budget includes the required 3:4 Title V match from state general funds through a state budget line item for the Child Development and Rehabilitation Center. The Oregon Legislature appropriates the state funds on a biennial basis. OCCYSHN programs are allocated approximately 30% in enabling services and the remainder in infrastructure services.

The budget for FY 2011 reported in Forms 2-5 are based on one year of the Legislative Approved Biennial Budget adopted in July 2009. The level of the Block Grant is based in the current FY 2010 award. The budget also does not include any current federal or other grant applications that are not yet awarded.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.